# ARCHIVES OF SURGERY.

JULY, 1893.

## MODES OF RECOVERY AS AN AID TO ESSENTIAL DIAGNOSIS.*

In the attempt to determine the essential nature of certain forms of constitutional disease, I cannot but think that we might make much use of the knowledge gained from results of special methods of treatment. Of the remedies which may be used in this way as a test of the real nature of certain skin diseases, arsenic stands in a foremost place. I think it may be said that we know for certain three things in respect to it: First, and by far the most important, it will in nine out of ten cases of typical pemphigus immediately stop the formation of bullæ, and, if persevered in, cure the disease. Next, it will in all cases of psoriasis, if pushed, cause the scales to fall, and very often bring about a cure. Thirdly, in cases in which herpes has been frequently recurrent, the continued use of arsenic will—with a few exceptions—definitely prevent such recurrences. From these facts we may fairly infer that any malady which arsenic can arrest definitely and speedily is probably in some alliance as to its real nature with one or other of those mentioned. It becomes, I think, very important in reference to all the different forms of skin disease which we may suspect of constitutional origin, to ascertain by careful observation what influence arsenic has

* I use the term "Essential" as denoting an attempt to recognise the nature of a disease as apart from the more outside achievement of giving it a name.

on them. In the attempt to determine this influence, detailed narratives are the only trustworthy form in which the facts can be recorded. Statistics may be very fallacious, and so also, when we remember how very complex our prescriptions often are, may be statements that patients appear to have derived benefit whilst taking the drug. For the purpose to which I refer we want conclusive proof, if possible repeated several times in the same case, that arsenic did in the most explicit manner prevent the production of the morbid phenomena.

The boy who was the subject of portrait No. XXIV., in the New Sydenham Society's Atlas, afforded a good instance of what is meant. In him an eruption which was erythematous only, and which never showed any tendency to produce bullæ, always cleared away immediately when arsenic was given. The disease relapsed repeatedly, but never with its original severity, and it was always cured so definitely by arsenic, that at length the mother of the child became able to identify premonitory symptoms (fretfulness, &c.), and at once resorted to the specific. I have published this case in detail in the descriptive catalogue of the Atlas, my narrative extending over nine years, and recording finally a well-tested cure. During the last six years of this period there had been no recurrence.

In this case the disease was certainly not very closely allied with pemphigus, since it had occurred in repeated outbreaks, and had frequently disappeared completely, independently of the use of arsenic. Pemphigus diutinus is, as its name implies, a persisting disease. The effect of arsenic in entirely preventing the development of outbreaks, and in finally conquering the tendency to them, was, however, as definite as could be well imagined.

My inference from these facts would be that the disease in its essential nature probably stood between a herpes and a pemphigus. It was recurrent, and capable of spontaneous cure, like a herpes; but it persisted much longer than herpes usually does, and was attended by the grave disturbance of general health which we witness in pemphigus.

The disease which is now known as Dermatitis Herpeti-

formis, and concerning which we owe so much to the writings of Dr. Duhring,* is one in which the effects of arsenic appear to be variable. In many of the cases recorded it is expressly stated that arsenic did not cure, whilst in others it was beneficial. It must, perhaps, be admitted that, in spite of all that has been written, it remains difficult to form a limitary definition of this disease. I would venture to suggest that in all cases which may be recorded in future, very careful attention should be given to ascertaining whether or not arsenic did exert any definite influence over the eruption. The drug should be used alone, and should, if necessary, be pushed. It might, not improbably, be found that the cases would divide themselves into two groups, one definitely amenable to arsenic, and the other not. We must carefully distinguish between those cases in which arsenic acts directly, as in pemphigus, and those in which a long administration is necessary. In pemphigus, as a rule, no fresh bullæ form after twenty-four hours' use of the drug; and in such cases it is difficult not to believe that the effect is produced through the nervous system: what we know as to the nature of herpes much favours such a supposition. It is quite possible, however, that in other cases, where prolonged administration is necessary, that the effect may be due to the actual introduction of arsenic into the tissues involved in disease. Such an hypothesis is perhaps the most probable as regards the influence of arsenic on a new growth. I am about to record two cases in which arsenic acted in the most specific and definite manner in the cure of dermatitis. In both its efficacy was tested over and over again, and was always the same. I am not sure but that some dermatologists would claim them both as examples of Duhring's malady. They presented, however, very marked differences from each other as regards the type of the eruption. The feature in which they agreed—and it is one which I think justifies me in placing them side by side—was that they were curable by the same drug.

The following are the notes of the first of the cases. The

* Dr. Duhring's papers on this remarkable malady have been collected in a recent volume published by the New Sydenham Society.

patient was an attendant in a lunatic asylum, and was sent to me by a medical man who had the misfortune to be placed under his care. I will give the notes as I took them at the time.

*Pemphigus Herpetiformis of four years' duration—Immediate arrest by Arsenic—Relapses whenever the drug was suspended—Cure after two years' treatment.*

The following are the first notes of this remarkable case:—

A tall, well-developed man, aged 24, single, who had never had syphilis (Mr. W. H——).

His liability to the eruption began in the summer of 1886. He was then an attendant in an asylum. It commenced as "a bright red rash across the loins." Two months later it began to spread, and came out on his thighs, back, and genitals. From that time to this he has never had his skin quite clear. He has, of course, been under many doctors, and he has attended at special institutions.

He is worse in the winter months, and better in hot weather. He is now always chilly unless taking exercise. This liability is new to him. In boyhood he did not suffer from cold, and never had chilblains. He believes that arsenic always for a time arrests the eruption, but it never cures it quite.

The eruption has been all but universal. The only parts which have been exempt are the middle of the chest and the corresponding parts of the back.

Before he was liable to this eruption, he was very prone to sore throats, which are in his family; they used to keep him in bed a week at a time. Since his liability to the eruption he has had no sore throats. The eruption itself, however, sometimes extends to his mouth and throat. Every medical man who has seen the case has called the disease "pemphigus," and with that diagnosis he brings a letter of introduction to me from my friend Dr. G——, of E——.

The above description applies to Mr. H——'s state when I first saw him on February 23, 1890. It must be understood that the eruption had varied much at different times. When

I saw him he had nothing approaching to a bulla. On his neck and ears were numerous small vesications, but none were larger than peas. On his back and sides of abdomen the eruption consisted of groups of spots which were, apparently, dried-up vesicles, and which, arranged in a somewhat corymbiform pattern, looked much like receding herpes zoster. They were symmetrical, and occupied almost the entire surface. On his limbs the eruption was much of the same character, but less corymbiform; on the legs more inclined to form scabs, and on the forearms presenting the condition of erythematous areas only. There were but few spots on his face, and ill-marked in character. His scalp hair was thin. He said that it had been "brought off by the eruption," and that he had often had crops of vesicles over the whole head. His genitals were free, but had, he said, often suffered. The front of his chest and the outer scapular regions of back were quite free, and showed neither pigmentation nor scars. On other parts the skin was in many regions deeply browned, and covered with little scars which the eruption had left.

I thought at first sight that his palms were free, but he showed that there were some deeply-placed spots which were threatening to vesicate. These were more plentiful on the joints of the fingers than in the palms. His own explanation was the skin was too thick for the fluid to get to the surface, and he said that the blisters would dry up and then cause the skin to peel. They made his hands feel stiff and sore. He had often had both palms and soles affected. The nails had always remained quite free, and were hard and brightly polished.

I inquired whether he had ever had large bullæ anywhere. The largest had, he thought, been on his ears, and were as big as shillings. It did not seem that on other parts they had ever been bigger than peas, and in many instances he described pustules rather than vesications on his thighs and abdomen. Throughout he had maintained good health, and had taken food well. He was accustomed to beer three times a day. His bowels were usually rather costive. His eruption had made him, he said, weary of his life, for he

was never well, and the irritation often prevented him from sleeping, and tormented him during the day.

As regards the occurrence of the eruption in his mouth, he asserted that it often came there; but there was nothing to be seen when he was with me.

The prescription which I ordered contained four minims of each of Pearson's and Fowler's solutions of arsenic. This was commenced on February 23, 1890, and on March 4th the patient reported that he had never been so well during the past four years. There was not a single vesicle left, and the skin was quite clear, excepting for numerous small pigmented scars. He stated that the spots began to disappear on the day following the commencement of the medicine. We had used no local application whatever.

On June 2nd my notes state that the eruption was threatening to appear again, in spite of the continuance of the arsenic. During the four months which had intervened, he had been almost wholly free, but had always found that if he left off his medicine for a week some fresh spots would come out. "His present relapse, although decided, is but slight. He has, however, some groups of spots arranged almost like herpes on the borders of his armpits, in the bends of his elbows, in the groins, and along the iliac crests. They are arranged quite symmetrically. There is one little spot just above the inner canthus of each eye. He complains that his skin generally feels hot. He says that he always knows where a vesicle is coming, a day or two before it appears, by a burning sensation (this is exactly what occurs in herpes). The vesicles are exceedingly small, and can hardly count as bullæ. They are coming out exactly where the white scars left by former eruptions are most abundant. There is some congestion of the skin in streaks about the groups of spots (again just like herpes). He says that he has not felt so well for ten years past as during the four months during which he has been free from the eruption and has been taking arsenic. I find that he has been drinking beer more freely, and I have my doubts as to whether he has continued his medicine regularly."

Advised to leave off beer entirely, and to take his medicine more punctually.

My next note is on August 21st, and records that for nearly three months he had been free from eruption. There had been no vesications whatever, but a few little hard spots would still occur occasionally on his arms, between his fingers, and on the sides of his heels. These did not vesicate nor itch, but would persist for a week or more, and then disappear. I had increased the dose of the arsenic, and added a little opium and two grains of quinine. Excepting occasional diarrhœa, there was no evidence of disagreement of the arsenic, although he was now taking ten minims four times a day.

On October 2nd my notes state that, the medicine having been left off for three days on account of diarrhœa, a few fresh blisters had appeared on the face; they had, however, soon vanished on his resuming the medicine. He had now for some months been quite free on the body, but was still liable to little red spots on the feet, from which the skin would peel. It seemed possible that these were due to the arsenic, as he had not been liable to them previously. He was now taking twelve minims (six of each of the preparations) four times a day, with two grains of quinine. He was gaining flesh.

On October 30th he was still quite free from eruption, but suffering much inconvenience from excessive perspiration of his feet. They perspired so much that his socks were soaked, and the skin became sodden like a washerwoman's hands. The softened epidermis was in places lifted by fluid under it. His hands were not affected. There was no tingling or numbness about his feet.

As I attributed the condition of his feet, described in the last note, to the arsenic, I advised him to leave it off entirely for a time, and substituted tincture of belladonna in ten-minim doses; the quinine pill was continued.

On November 4th (that is exactly one week after leaving off his arsenic) Mr. H—— returned to me with a very decided tendency to a relapse of his eruption. Thus we had a demonstration that it had been the arsenic, and not the

quinine, which had kept it in abeyance. On his face, arms, and body there had appeared a great number of very small vesicles, which were very irritable. The perspiration of his feet was much less. I felt obliged to advise him to again take the arsenic.

My note on December 4th states that since we began the arsenic again the spots have ceased to appear. His soles have, however, again begun to be irritable and to perspire profusely; they are erythematous just on the parts pressed upon in standing, and the epidermis becomes sodden, and can be rubbed off every morning. He says that "he could wring his socks several times a day from the perspiration." It is a hot perspiration, and his feet "steam." He is engaged in an occupation which involves much standing. His right foot easily goes to sleep.

After the last date we never again gave the arsenic in such large doses; but we were obliged to continue it, in order to keep him clear of the eruption, and to combine with it considerable doses of opium, in order to prevent diarrhœa. It may possibly have been from the opium that we observed some failure in his general health.

On February 1, 1891, I wrote:—"He looks wan and pale, and thinks that he has been losing flesh for three months. His medicine had not appeared to disagree in any definite manner until a week ago, when it caused griping and diarrhœa. The symptoms used to come on five minutes after the dose. His eyes became very yellow. He left off the medicine three days ago, and the diarrhœa, &c., at once ceased. He has become very swarthy, parts of his trunk, especially over his hips, are almost black. The colour is diffused. Although he has left off the medicine only a few days, he is already threatened with some return of the old eruption. On the trunk there are little red papules under the skin, but on the face there are a few very small vesicles. His feet still perspire very much, and are somewhat congested, but they are not nearly so red as they were formerly. The belladonna appears to have much diminished both the perspiration and the congestion."

At the date of this last note, I made a demonstration of

the patient before a post-graduate class as an example of the discoloration of the skin which we sometimes observe from arsenic, and also to show the condition of the soles of the feet. This was on February 4th, and I then advised him to leave off the arsenic, as I feared it was injuring his health. Within three days of doing so, however, some fresh spots appeared, and of his own accord he resumed the use of the drug in half-doses. When he came to me again on February 27th, the eruption appeared to be kept in check, but not quite completely so. He had on various parts little erythematous papules which showed some tendency to vesicate, and there were a few small definite bullæ on his face; his feet were hot and perspiring, and the palms of his hands showed little corn-like indurations.

It is not necessary to continue the detailed notes of this remarkable case any further. Enough has been recorded to prove, beyond any doubt, that arsenic, and arsenic alone, possessed the power of controlling the eruption. The patient is still under my occasional observation. He is in good health, and has recently married. I have allowed him during the last year to take his arsenic mixture at his own discretion, insisting, however, that he should only take just enough to keep his skin free. Much smaller doses suffice for that purpose now than formerly, and he is often able to leave it off for a few weeks together. The discoloration of his skin has to a large extent disappeared, and he is quite free from the intolerable itching and burning sensations which used to torment him. We may record, therefore, that the treatment has in the end conquered the malady.

A few words may be permitted as to the real nature of the disease. I might sum up my own impressions by calling it herpetiform pemphigus. It was a symmetrical eruption, but its development and the grouping of the spots were like herpes. Some of the vesicles, however, were globular, just like those of pemphigus, and they showed none of the tendency to spontaneous disappearance which characterises herpes. They yielded to arsenic just as promptly as pemphigus does, and recurred as speedily when it was left off. The effects of that remedy afford us, I think, very valuable evidence as to the essential nature of the disease.

*A case of Herpetiform Pemphigus which relapsed frequently during many years, and was always controlled by Arsenic.*

The second case to which I have referred, is that of a patient named Esther Ann B——. This woman was aged 42 in 1875, at which date I had her portrait taken, and exhibited it in the annual Museum of the Medical Association at Edinburgh. I then named it "A pruriginous herpetic, or vesicating eruption, leaving scars, frequently relapsing, and often cured definitely by arsenic." Mrs. B——'s history then extended back several years, and was as follows :—Before the eruption first appeared, she felt weak and languid; during her pregnancies she had often suffered from pruritus vulvæ. The eruption began in 1870, just after her last confinement; the parts first affected were, as far as she could remember, the head and neck. During 1871 and 1872 she had much distress from the eruption, which, although better at times, never left her altogether. It displayed however, distinctly a tendency to die away, as she called it, and would then again relapse. In 1872, at Christmas, she had a very bad attack, and for the first time came under my observation at the Hospital for Diseases of the Skin. She was at this time a widow, having lost her husband about a year after the beginning of the eruption. We did not at first give arsenic, but on October 3, 1873, this remedy was prescribed in three-minim doses of Fowler's solution. On the 17th of that month she was much better, and on the 31st she was quite well. In December she had a relapse, having left off her medicine, and in January again she was quite well. It would be tedious to recapitulate in detail the account of the relapses and their treatment. At the time that I first saw her, she had for about four years never been quite free, and never nearly so for more than a few weeks at a time. After the treatment by arsenic was commenced, she remained under my observation more than four years, but I often did not see her more than once or twice in a year. A few weeks of the arsenical treatment always sufficed to clear her skin, and on several occasions, whilst continuing it more or less regularly, she had an entire year without a relapse. A severe relapse, con-

sequent upon her having left off her medicine for some time, occurred at Christmas, 1875; and it is her state when she presented herself at the Hospital at that date, that is depicted in the excellent portrait by Burgess which I have mentioned. It may be well, therefore, in connection with that date and the portrait, to describe the characters of the eruption.

It may be said, in brief, to have partaken of the features of herpes and of pemphigus. The vesicles and little bullæ were arranged in streaks and groups, exactly like those of herpes; and although some of the bullæ were large enough to have been called pemphigus, none of them were quite round. The vesicles occurred in great abundance on the back and shoulders, also on the chest, upper arms, extensor surfaces of forearms, on the hands, and on the forehead, cheeks and neck. Formerly they had been present on the scalp, amongst the hair, and on the thighs and legs. Some of the vesicles were distinctly compound, like those of herpes; and others formed little blebs, the size of horse-beans. Before they appeared there was always much burning and itching, and when they dried up, they left the skin intensely pruriginous. Amongst the parts which were definitely avoided were the loins, the genitals, and the upper parts of the thighs. Mrs. B—— looked older than her years, and was somewat pale and haggard, but it must be borne in mind that in addition to this trouble, she had had a good deal of domestic sorrow. She had borne several children (all before the commencement of her skin disease), and five of these were living. None of her children had displayed any irritability of skin, and she herself had never had anything which she called nettle-rash.

My notes on December 10, 1875, when Mrs. B—— attended with a relapse, state that she had then been free for the greater part of a year. She was, as usual, quickly cured by the arsenic mixture. My note on April 18, 1877, states that she had left off the medicine for six months, and that she had been entirely free from eruption for about a year. The spots had been returning for about a fortnight, and many of them were already beginning to dry up. On this occasion, although her spots had for the most part disappeared in the

course of a few weeks, she remained under treatment till June. After this last date (June, 1877) I have no further notes of her case, but I believe that she continued to attend, as formerly, once or twice in the year, for several years longer; and that the arsenic continued to display the same specific power as before, in keeping her skin clear, so long as she continued to take it.

If we venture to assert that in this case the specific power of arsenic was just as definitely proved as it usually is in pemphigus, we must admit that the tendency to severe relapses was considerably greater, or perhaps it ought to be said that the relapses, when they did occur, were more severe. The state of the eruption as depicted in the portrait (which shows the shoulders covered with eruption) sufficiently proves this assertion. When common pemphigus has been cured by arsenic, the relapses are, I believe, not usually severe; but in this instance they were as bad as the original attack. Had the poor woman been able to give herself more attention, and had she been willing to continue her attendance at the hospital and to go on with her medicine when quite well, I think it not improbable that all relapses would have been avoided. It will be seen that on several occasions she remained quite free, in spite of having left off the medicine, for several months at a time.

The appropriate name for such a disease as this is, I think, "Herpes-pemphigus." I have no doubt that this latter name fairly expresses its relationships, and that, as to cause, it partook of the nature both of herpes and of pemphigus. In some of its features it resembled both, and the drug which cures the one and prevents the other exhibited in a most unquestionable manner its efficiency for both purposes. The case differs in some features, although not, I think, essentially, from the one which has preceded it.*

* In connection with these cases, I may again ask the reader's attention to the fact that the New Sydenham Society has just reprinted a collection of the important papers which Dr. Duhring, of Philadelphia has from time to time published on the disease which he names Dermatitis Herpetiformis. I have little doubt that Dr. Duhring will claim my cases as examples of his malady. I have preferred, however, in the attempt to ascertain their essential nature, to let them stand unnamed. Dr. Duhring's papers should be read carefully by all interested in the subject.

(*To be continued.*)

## ON PORRIGO AS AN EXAMPLE OF SURFACE-CONTAGION.

(*Part of a Post-Graduate Lecture delivered Jan.* 31, 1893.)

I PURPOSE, to-day, to ask your attention to a large natural group of skin diseases, which begin and spread entirely by what we may call surface-contagion. We will put aside for the present all those eruptions which are due to surface-irritation, such as scabies, eruptions from pediculi, heat eruptions, and the like. We will take only those in which the clinical evidence, in some cases strengthened by the employment of the microscope and in others not, makes it almost certain that there exists a contagious materies, which is transferred from part to part on the exterior of the body, and to which all that we observe is due. The first group of skin diseases due to surface-contagion is that of the maladies which have been proved to be of cryptogamic origin. To this group we apply the name TINEA. We count in it tinea favosa, or common favus; tinea tonsurans, or common ringworm; and tinea versicolor, the well-known liver-spots. All these begin by the implantation of a fungus on the skin, and all have a parent patch from which we assume, almost with certainty, that the rest are developed. In all, microscopic confirmation of the diagnosis is usually very easily obtained. They are contagious, and contagious only; and although the liability to them is much influenced by the age of the patient, and possibly somewhat by the special anatomical characters of his skin and hair, in none of them does the state of the general health exercise any great influence. I leave these diseases aside for the present, and with them a few others which are, either certainly or probably, allied to them, such as the varieties of ringworm which occur in hot climates, the

so-called eczema marginatum, and alopecia areata. Before, however, quite leaving them, it may be desirable to remark, in order to obtain as much light as we can upon other branches of this subject, that whilst both favus and ringworm are most common in childhood, tinea versicolor is never seen until a near approach to adult age, and that, with the exception that common ringworm usually appears to wear itself out as adult age is approached, yet that with this partial exception, all of them are capable of quite indefinite duration. Lastly, let me add that none of them are, with the rarest exceptions ever seen in old age.

Our forefathers used very freely the word "porrigo," and applied it with various adjectives not only to the diseases which we now place in the tinea group, but also to various forms of eczema, as well as to the special malady which I am now about to describe. On account of the vagueness of its meaning, the name in question has of late years fallen almost into disuse. I venture to ask that we should rehabilitate it, but in doing so, let me be understood to desire that it should receive a strict and limitary definition. I would apply the term porrigo—and this is no new use of the word, for it is what I was taught in my student days—to an eruption which is sometimes classed, but very erroneously, as eczema, but which is contagious, and contagious only, and which is very easily curable by certain local applications. I infer its nature partly from the means by which it is cured, and may at once say on this head that the most efficient remedy is the application of an ointment containing some preparation of mercury, the ammonio-chloride, or the nitric-oxide. The simplest examples of what I mean by the term porrigo occur in cases which are tolerably common in family practice, in which a child of delicate skin has had a scratch which has festered. From the secretion thus produced other sores may be developed, either near to it or on distant parts of the body. If there be other young children in the family, they very probably will catch the disease by contagion, and the mother or nurse who attends to them may very likely get sores on her fingers. Both in the children and in the nurse there is a remarkable proneness for the suppuration to affect the roots of the nails. The next

example of the disease which I will mention is that which occurs on the heads of neglected children who are troubled with lice. In a large majority of cases pediculi are not attended by any inflammation of the skin which they irritate: at any rate, there is no fluid effusion on its surface. Not unfrequently, however, in children in whom the skin is, perhaps, especially irritable, or in whom the scratching has been exceptionally violent, festers form, and the whole scalp becomes involved in inflammation, attended by much fluid effusion, and the formation of thick crusts. Now the character of these crusts on the scalp is exactly the same as those seen occasionally when porrigo, beginning from a scratch, has spread to the hairy scalp. In both cases the scab is thick, heaped up, resembling dried honey in appearance, and having a more or less offensive smell. In both cases it is very likely that the lymphatic glands in the neck will become enlarged, and at the same time very unlikely that they will suppurate.

A third group of porrigo cases, much less common than the other two, but in which yet more virulent properties of contagion are often displayed, is that in which the disease begins from vaccination. The annals of vaccination, and especially those of the anti-vaccinators, contain many accounts of epidemics of impetigo which appeared to originate from vaccination sores. In all cases it is the vaccinated child itself which first suffers, but from it the disease may spread to brothers and sisters, parents and nurses. The features of the eruption in all these cases is similar. The initial lesion is not a pustule, but a little vesication or bleb, the covering of which is very delicate and soon gives way. On the abrasion thus formed a heaped-up crust is produced. The skin does not become diffusedly inflamed, and on the parts intervening between the crusts it does not even show any redness. The contagious forms of porrigo originating from vaccination are curable by a white precipitate ointment, just as easily as are the other forms. In the vaccinated child it is always the parts near to the vaccination sores themselves which are first infected, and we are therefore, I think, entitled to assume that it is a local inflammation, consequent on injury to the skin, and that it has nothing to do with vaccinia as a specific febrile

malady. I have recently had an opportunity for studying a workhouse epidemic of this form of porrigo, and you will find the facts described at some length in the third volume of my ARCHIVES. It occurred in the maternity department of the St. Pancras Workhouse. It began on a vaccinated infant, but it subsequently attacked all the infants born in the establishment, although vaccination was desisted from. The eruption, on account of its being attended by bullæ, was at first called "pemphigus," as indeed other epidemics of a similar kind have been named, but it had nothing whatever in common with true pemphigus, which is a persisting and constitutional disease, curable only by arsenic, whereas this very quickly got well under a simple local treatment. In many of the infants affected in the workhouse the spots occurred on the hands as well as on other parts, and not unfrequently the finger-nails suffered. The eruption was not as a rule developed with symmetry, but occurred with much greater severity on some parts than on others. In several cases the mother of the affected infant contracted the disease, and in these instances the eruption always appeared on the skin of the mamma or adjacent parts where the infant's head had rested. Thus I feel sure you will admit that I am entitled to assume that this malady was a local one, and not due to any infection in the system generally. You will find in my ARCHIVES the description also of another epidemic, not occurring in a workhouse, but which spread from house to house amongst new-born infants and others who were attended by a nursing sisterhood. The facts of these two epidemics alike made it certain that the materies of contagion was a very subtle one, and not to be destroyed by any ordinary precautions of cleanliness. In the case of the workhouse this conclusion was very strongly enforced by the fact that although the wards were disused for six weeks, whitewashed, &c., and the nurses given a holiday, yet the disease reappeared as soon as the wards were reopened. I have little doubt that in both epidemics the contagion was spread by the hands of the nurses, or perhaps by their dress, and this in spite of the most sedulous washing and the employment of antiseptics.

There can be no sort of difficulty in distinguishing porrigo,

such as I have here described it, from eczema; and, as a matter of fact, the diagnosis has been well understood for the last half-century. As a student I was myself taught that porrigo could be cured in a week or two, whilst eczema might take many months, and the difference between the thin crusts with diffuse congestion in the one, and the heaped-up crusts without any general redness in the other, was carefully pointed out. If, however, other means of diagnosis were wanting, the case is one in which the difference in success of measures of treatment is abundantly sufficient.

In the year 1862, a gentleman to whom dermatology is much indebted, the late Dr. Tilbury Fox, described a malady which he named "impetigo contagiosa," and his account of it was subsequently accepted by various other authorities. Dr. Fox admitted, however, that it was the same malady which had been called porrigo by others; and most of his statements coincide very exactly with what I have just said about it, and it is certain I derived my knowledge of it long before he wrote. He, however, adds certain features to his impetigo contagiosa which are quite foreign to my porrigo. He asserts that it is a febrile malady, preceded occasionally by smart fever, and adds, "There is clearly an affection of the system at large before the occurrence of any eruption." He asserts also that the natural course of the disease is a short and definite one. Now these statements are not applicable to porrigo as I understand it. I do not believe that the slightest febrile disturbance precedes the eruption, but that the latter always begins locally, from the inoculation of a contagious secretion. Nor, although the disease is usually of short duration, do I believe that it runs a definite course, or that it has any tendency to spontaneous cessation. I would call it rather a disease that is easily curable; and on this point, as well as on many others, in spite of what I have just quoted, Dr. Fox's experience seems to have been the same as my own. He, too, believed that "the secretion is an active agent, by means of inoculation, self-practised by the patient in scratching, in transmitting the disease from one part to another." He, too, wrote, "I invariably use an ointment containing five grains of the ammonio-chloride of mercury; this rapidly cures the

disease." I cannot, therefore, doubt that most of the cases which supplied Dr. Tilbury Fox with materials for his conception of impetigo contagiosa were examples of what had long been called porrigo, and for which I should still prefer to retain that name. It remains, however, a question, which I by no means wish to put aside hastily, whether there are any cases which are really constitutional in origin, preceded by fever, and which show a tendency to run a definite course, and to recover spontaneously, independently of treatment. It is, however, I think, not too much to ask that any one who in the future asserts that there are such cases, should record the facts carefully, giving the temperatures during the stage of incubation, and that in order that we may believe the disease runs its course naturally and comes to an end spontaneously, he should abstain from interfering with it by the means of so efficient a remedy as the ammonio-chloride of mercury.

## ON CERTAIN DISEASES OF THE TONGUE.

(*Continued from Vol. IV., p.* 322.)

### *The Filmy Tongue* (see Vol. IV., p. 318).

One of the best marked examples of the *filmy tongue* which I have seen occurred in the case of a man named K——, who was brought to me by Dr. Matheson, of Soho Square. He was forty-five years of age, a heavy smoker, quite free from skin disease, and, excepting a little dyspepsia, in good health. The patches on his tongue, which had given him great trouble, had been first noticed about fourteen months before I saw him. He thought that a little blister caused by smoking was the first thing that he noticed, but about this there might be some doubt. Nothing whatever of the nature of an excoriation had occurred since. The patches were, as usual, symmetrical, and, again as usual, of larger size on one side than on the other. They extended lengthwise, as two broad streaks, one on each side, near to, but not touching, the edge. In front of these principal streaks there was a number of small spots which advanced up to the tip of the tongue. Inside the buccal pouches was a number of pearly white streaks which branched. These were chiefly far back in the cheek, and not, like the smoker's patch, near to the commissure. Many of his teeth were capped with gold, but none of them stopped with amalgam. The patches were, as usual, rather ill-defined at their edges, and they were distinctly perceptible to the finger as being slightly rougher and harder than the rest of the tongue. When looked at with the lens they were seen to be composed of slightly-raised, rounded, filiform papillæ, which were glued together by a filmy, white material.

We advised Mr. K—— that he should at once leave off

smoking, and prescribed a mixture containing arsenic, with a solution of chromic acid for local application.

I did not see Mr. K—— for a second time until April 13, 1893, about eight months after his first visit. He then called on me again with Dr. Matheson. He reported that he had never smoked since our last consultation, and said that, within a month of it, as he thought as a result of the medicine, the patches had almost diappeared. He was so nearly well that the medicine was left off. During the last month or two the tongue had relapsed, and, in spite of again taking the medicine, there had been no improvement. The patches were much as at the time of the former consultation, but not so conspicuous; more especially those in the cheek had much diminished. No skin disease whatever had developed. Although there was not the slightest reason to suspect syphilis, I now suggested that, as the arsenic had failed, he should try the bichloride of mercury.

Another example of the filmy tongue, exactly like the rest, was shown me by Dr. Abraham at the Hospital for Skin Diseases. The patient was a shopman of about twenty-six years of age, who had never had syphilis, and in whom we could detect no skin disease. Asked if the patches gave him any trouble, he said none whatever, excepting that it was very inconvenient coming to the hospital. This was in February, 1893.

Another very good example of filmy patches on the tongue occurred in the person of Mrs. D——, who was sent to me by Dr. Jeaffreson, of Wandsworth. This lady was very stout, and had suffered from threatenings of gout in various forms. Her age was fifty-two. She had had intertrigo-eczema under her breasts, but this had been cured, and she had no other form of skin disease. The state of her tongue was most peculiar. On the greater part of its surface the papillæ were long; but on both sides on its anterior half there were symmetrical patches, which were quite smooth and slightly glazed. They were a little depressed below the level of the surrounding papillæ, and had a slight bluish tinge. On careful inspection it could be seen that the papillæ on these patches were by no means absent, but were smoothed over and, as it were, glued

together by what looked like a thin layer of bluish size. The patches were not abruptly rounded, and were in some parts accurately defined, and in others not so. One, as a sort of streak, occupied the median fissure of the tongue. There were similar white patches, but longer and more streak-like, in the cheek pouches about the line where the teeth would meet.

In this case no special cause could be assigned for the patches on the tongue, and they caused scarcely any inconvenience. As usual, there was but little sense of soreness. It was conjectured that they might have been caused by drinking effervescent waters too freely, but about this there was nothing very definite to be said. I saw Mrs. D—— first on April 26, 1893, two or three months after the patches had first been noticed. She came to me again on May 20th, when I found the conditions exactly as before.

### *Pneumonia after Écraseur-Excision of the Tongue for Cancer—Details of after-treatment.*

In an address which I gave at Liverpool, about a year ago, I took credit, I hope not boastfully—and not to myself, but to my mode of operating—for the fact that I had never in private practice lost a single patient after excision of the tongue. My operations of late years have all been by means of the écraseur with a cold wire, thus entirely avoiding all risk of hæmorrhage and subsequent danger from the passage of blood into the trachea. The critics of this operation are fond of suggesting that the wound left by the écraseur is apt to be for a time in an unhealthy condition, such as may easily permit of septic infection of the lungs. To this my reply has always been that, although I have done many such operations, I have never, in a single instance, encountered pneumonia afterwards. I am speaking as to the results of private practice, for at the London Hospital I did once lose a patient from pneumonia after excision of the tongue. Nor am I any longer in the position to renew my boast as to operations in private, for I have just had to deal with a very critical case. The facts of this case are briefly as follows:—

UNIVERSITY COLLEGE HOSPITAL
MEDICAL SCHOOL LIBRARY.

More than eight years ago I performed, in the case of Major O'D——, then aged 45, a very free surface operation on account of sclerosis with a papillary condition on the dorsum of his tongue. It was a matter of debate whether the condition was actually epithelial cancer or not. I cut away the tip and surface very freely with scissors. The parts healed well, and he continued his vocation as a police magistrate in Ireland for eight years. At the end of this time he returned to me with an extensive ulceration on the surface of what remained of his tongue, which was unquestionably cancerous. The condition had been developed during the last six months. He was admitted into a surgical home, and I removed the whole of his tongue by means of the wire écraseur. It was all but a bloodless operation, and certainly no blood passed into his trachea. The progress was very satisfactory during the first four days. On the fifth he seemed languid, and on the sixth I allowed him to take an hour's drive in the open air, during very warm weather. After his drive he had a rigor, and on the next day there was double pneumonia. During the ten days following he was in a critical condition, his temperatures being variable and sometimes high. I had the assistance of Sir Andrew Clark and Dr. Douglas Powell in the treatment at this stage, and eventually complete recovery ensued. It was a question whether the pneumonia and complicating pleurisy were more probably due to septic infection from the mouth or to exposure on the occasion of his drive. The condition of the wound in the mouth had been satisfactory throughout, and, as the patient had eighteen months previously suffered from a severe attack of pneumonia during influenza, it is perhaps fair to assume that the operation on the tongue had really nothing to do with it on the present occasion. I am, however, bound to record the case, having so recently and so strongly asserted that écraseur operations are not followed by lung complication. In reference to this point I have to ask attention to a little matter of detail. My after-treatment of these operations has always been by a mouth-wash of spirits of wine. This the patient is made to use very freely indeed, constantly rinsing his mouth and

spitting out the fluid. In the present instance, for the first time in my practice, a spray was used, by a too zealous nurse, who had employed it in other cases. It occurs to me as quite possible that a spray is the very best means of facilitating the inhalation of septic particles, and that very probably a mouth-wash is far safer. I shall most certainly in all future cases forbid the use of the spray, and keep strictly to an old, well-tried friend. The mouth-wash which I use is made by putting two tablespoonfuls of spirits of wine into a tumblerful of water. If the wound is unhealthy, I frequently have it swabbed with a much stronger solution.

## EPIDEMICS OF ECZEMA-ERYSIPELAS.

Great attention was attracted about two years ago to the occurrence of epidemics of a contagious form of eczema in two of our large London workhouse infirmaries. Dr. Savill, of the Paddington Infirmary, who was the first to perceive the peculiarity and importance of the cases, subsequently published the results of his experience in a detailed and well illustrated essay. I have myself repeatedly alluded to these cases in my Archives, and have given some particulars of an epidemic of a similar kind, which had previously occurred in a lunatic asylum * in Scotland. My conjecture as to the real nature of this form of dermatitis is that it is a sort of hybrid between eczema and erysipelas, and that not improbably it is the presence of a micro-parasite, allied to that of erysipelas, which renders an eczematous process contagious from patient to patient. Through the kindness of Dr. Knox, of the Bethnal Green Sick Asylum, I have just been made acquainted with the facts as regards another epidemic of this remarkable disease, which has occurred during the present summer in the establishment under his charge. I have visited the Asylum twice and seen Dr. Knox's patients. No fewer than eighty-four cases have occurred, some of them only slight, but many severe, and there have been four deaths. For the most part middle-aged or elderly people have been sufferers, and all the deaths have occurred in those already enfeebled by age or disease. As to the character of the malady in this instance, I may briefly say that all the features present in the epidemics at Paddington and Marylebone have been repeated here. The cases have been for the most part indistinguishable from the isolated examples of

* The Greenock Parochial Asylum. An account of this epidemic has since been published by Dr. Elkins.

general eczema, which we frequently witness in aged persons. A case upon which I lectured in the Cleveland Street Hospital, and which was published three months ago in the Clinical Journal, may serve as a good example of the more severe type. In that instance the patient's hands and feet peeled in glove-like layers of epidermis exactly as Dr. Savill described it in his cases, and as I have recently witnessed it in Dr. Knox's patients. This extensive and very definite peeling has been relied upon as one of the distinguishing features of the cases which occur in epidemics. It is, however, I am sure, one that is common to all forms of acute dermatitis in the least approaching the type of erysipelas. Dr. Knox tells me that, in several of his cases in the acute stage, any one observing the patient's face, the swollen eyelids and distorted features, would have at once diagnosed erysipelas; and in this stage the temperatures were all somewhat high. After the most careful inquiries as to any probable cause, whether local or dietetic, Dr. Knox had been obliged, as were his predecessors in this matter, Dr. Savill, Mr. Lunn, and Dr. Elkins, to confess that he was baffled. There is not the slightest reason for believing that these epidemics are due to any special kind of soap, or to any particular form of food. They may begin apparently spontaneously, and the mode of transmission is by contagion only. The epidemic at Bethnal Green is now ceasing, and Dr. Knox tells me that he feels confident that it has been arrested by careful attention to the isolation of cases. It is not thought that it had its origin in the admission of cases from outside, for its first subjects were old inmates of the asylum; nor did it appear very evident, as regards the early cases, that it was conveyed by contagion. With but short intervals, cases developed in several different wards. It may, however, be plausibly suggested as regards these, that very possibly the medical attendants or the nurses were themselves the vehicles of the infection. Great attention has recently been paid to washing the hands, &c., with carbolic solutions, which was not done in the first instance. At one time Dr. Knox was inclined to believe that the disease was in some way connected with drinking milk; but this hypothesis

has, I believe, been abandoned. Although many of the cases have been severe, almost the entire surface being involved, yet in some it has been quite slight. Thus Dr. Knox himself and one or two of the nurses have had patches on the face and hands, though they were never sufficiently ill to be disabled for duty. Precisely parallel facts occurred during the epidemic at Paddington.

Thus then, to sum up, I think there can be no doubt that we have in these epidemics a form of dermatitis indistinguishable in its principal features from generalised eczema, but more rapid in its course, and showing a greater tendency to spontaneous recovery. Whilst, however, eczema as a rule shows little or no tendency to spread from person to person, we have here a virulently contagious malady. The febrile disturbance and œdematous swelling of the affected parts, the vesication, temporary crusting and subsequent peeling, are all features in which the disease resembles erysipelas. The malady is much more severe than eczema, and much less severe in a general way than erysipelas. At the same time it is more lasting than the latter, and less so than the former. That its natural and proper position is as a hybrid or connecting link between the two, I can feel little doubt. In support of this proposition I will venture to narrate the particulars of a few other cases taken from private practice, which appear to illustrate similar laws of pathological development.

As regards the absence of this form of disease in the Bethnal Green Infirmary in preceding years, I may note that Dr. Knox expressed himself, in the clearest manner, that it was new to him. He said that he had been at the infirmary many years, and had never before known such an outbreak. On this point I have made some inquiry at other institutions. The result has been a strong impression that cases of diffuse senile eczema are not more common in these infirmaries than they are in private practice, and that very rarely indeed does any suspicion occur as to its spreading by contagion.

During a visit about a year ago at the Lambeth Infirmary, for another purpose, I made inquiry as to the prevalence of eczema and allied forms of dermatitis. Dr. Lloyd, the

resident medical officer, informed me that he always has cases of general eczema in his wards, especially in aged persons. During the summer (1892) he thought he had had more than the average, but his attention would not have been attracted to their prevalence had not others referred to it. He showed me one case of rather unusual severity. The patient was a woman of between fifty and sixty. She had been admitted in August with dropsy, and three days after her admission had begun in "eczema" for the first time in her life. It had spread over the whole surface. When I saw her she was a good example of Dermatitis universalis or Pityriasis rubra. No portion of her skin was exempt. The nails were affected, though not very severely, and she had lost almost all her hair. The skin was everywhere dry, red, and scaly. She had emaciated considerably. The skin of her palms and soles was thickened. Although the dermatitis was absolutely universal, it was not, when I saw her, of extreme severity. I was told that it had been much worse.

I was not shown any other cases of eczema, and clearly the prevalence of the disease in this infirmary had not approached that which occurred at Paddington and Marylebone, and this summer at Bethnal Green.

*A case illustrating the theory of Erysipelas-Eczema.*

I saw, with Dr. Thyne (December 20, 1892), at Barnet, a very interesting case bearing upon the doctrine of erysipelas-eczema. There are two forms of this disease; one, in which it is symmetrical, attacking simultaneously, or almost so, both sides of the face, and closing the eyelids, and another in which it spreads from a single spot on one side aggressively over to the other. Possibly, however, these two apparently different forms differ really only in stage: the bilateral outbreaks occurring only in those who have had the disease before, and in whom it is frequently recurrent. The case which I am about to describe was a first attack. Our patient was a gentleman, little short of sixty, who had always enjoyed excellent health. His present ailment had commenced about ten days before I saw him, by redness about

the left nostril which spread upon the cheek. He did not feel ill, and was about his occupations as usual, when he first consulted Dr. Thyne. The latter detected a fissure inside the nostril, from which the disease had apparently spread. It was diagnosed as eczema. An ointment was prescribed for the fissure, and Mr. B—— was advised to keep his house. The fissure quickly healed, but the inflammation of the cheek continued to spread. A few days later, Mr. B—— made a journey in his carriage to London, with the result that he returned home feeling unwell, and with a considerable accession to his eczema. The question was now anxiously asked, Is the eczema erysipelas? To this a negative reply was given. It continued, however, to spread, closed the left eyelids by swelling, and passing over the bridge of the nose, advanced on the opposite cheek. It was at this stage, ten days after its commencement, that I was asked to see the case. Mr. B—— was not in bed, and said that he did not feel ill, but he admitted that he had no appetite, and was not comfortable. He denied having at any stage experienced anything like a rigor. His skin disease was certainly eczema. Two-thirds of his face, and the adjacent part of the left side of his neck, were involved in a red weeping inflammation, and in parts covered by a thin crust of dried secretion. He showed me the handkerchiefs which had been applied to his neck, demonstrating how free the secretion had been, and how it had stiffened the linen, like so much starch. His pulse was only 60, and I was told that his temperatures had been but little higher than normal. So far, then, the disease was clearly eczema. Let us look, however, at its other features. It was attended by œdematous swelling, which disfigured his features, and had quite closed one eye; it was advancing by contagion of continuity, and with an abruptly-defined edge. It had commenced at a definite point, and in connection with a little ulcer, and from that it had spread on all sides. These were all features characteristic of erysipelas. I had no hesitation in expressing to Dr. Thyne—not to our patient—the opinion that the disease, or rather shall I say the type of dermatitis, was a hybrid between eczema and erysipelas, and partook of the characters of both. We told

the patient that he must go to bed and be systematically treated. The prescription was an antimonial mixture, and a lead and spirit lotion.

After we had finished our consultation, a very interesting fact was elicited. Our patient had averred, in answer to inquiries as to former attacks, that all that he had experienced was once, when in Switzerland, a transitory attack of eczema in one leg, which had soon been completely cured. He subsequently remembered, however, that when a boy at school he had been cut on the top of his head by a piece of stone, and that he had subsequently been in bed several weeks on account of inflammation, spreading from the wound, which ran all over his face and neck. Clearly this had been an attack of traumatic erysipelas. Of the wound he showed us the scar. Although a period of more than forty years had elapsed since this illness, I am not disposed to believe that it was without its influence with reference to the present attack. Erysipelas appears always to leave its germs behind; and many cases have come under my notice in which patients who had once suffered, experienced second attacks after very long intervals. Such second attacks are, I think, always less severe than primary ones.

I do not see that anything could be gained by resisting in such a case as above the diagnosis of a hybrid malady. Beyond all doubt the dermatitis presented the local features and the clinical history of eczema and erysipelas mixed. It required the treatment for erysipelas, and its subsequent course will probably, to a considerable extent, fit with that disease. Yet that the constitutional disturbance attending it was far less than is usual with erysipelas cannot be doubted. Nor, I expect, will the cure prove so rapid or so complete as usual in erysipelas.

I need not here again insist upon the importance of the doctrine of this hybrid malady in reference to the explanation of eczema epidemics; concerning these I have already written fully. I may, however, just remind my readers that in many of these cases the disease began by a local patch, and then spread by auto-infection over the whole body. Some of the cases were attended with considerable constitutional dis-

turbance, and some ended fatally. Yet the disease was certainly eczematous in most of its characters. I suspect that, as a general rule, when eczema shows a tendency to advance by contagion and become universal, and especially when it is contagious to other persons, it partakes not only of the external features, but of the real nature of erysipelas.

Why, in the face of a large body of clinical evidence which suggests the contrary, we should persist in clinging to the doctrine that erysipelas is a specific fever and always keeps to its type, I may confess that I cannot see. The doctrine of its bacillary origin would not be endangered by a more elastic creed. Whenever any form of inflammation becomes contagious and yet keeps to its type, we may freely admit the probability that there is present some living organism by which the contagion is effected. Whilst, however, in all other departments of biology our conceptions of what constitutes specificity are receiving liberal modification, it seems very doubtful wisdom, when dealing with the causes of disease supposed to be specific, to trammel our thoughts by arbitrary limitations which the future may probably prove to have had no sound foundation.

## SCROFULOUS ULCERS ON THE LEGS (BAZIN'S MALADY).

The attention of dermatologists, both in London and in Paris, has been of late directed to an important class of cases in which multiple ulcers occur on the legs of young persons, and assume features which might easily be mistaken for those characteristic of syphilis. A description written by M. Bazin many years ago, and which had been forgotten, has been found to apply with considerable accuracy to some at least of these cases. This distinguished observer named the malady Erythème induré des scrophuleux, and wrote of it under that name in some detail. Whilst, however, he fully recognised some of the principal features of the malady, it may be objected to the name which he gave that it does not designate the most prominent of them, that is the ulceration. These cases are of great importance, not alone on account of the difficulties in their treatment, but because, from their close resemblance to syphilis, they may easily give rise to unfounded suspicions and induce the adoption of uncalled-for medication. I may freely confess that in former years I have myself been led into error, and at the present time, with the exception of those who have paid especial attention to the subject, I believe that the diagnosis of syphilis is the one almost invariably made and acted upon.

I purpose on the present occasion to narrate as briefly and explicitly as I can my own experience in respect to these cases; but, before doing so, it is right that I should say that I am specially indebted to Dr. Colcott Fox for having called my attention to M. Bazin's description,* and for having shown

* The following translations are from Dr. Fox's pen:—"In second edition, 1861, of 'Leçons sur la Scrofule,' Bazin writes as follows: 'Erythema indurata, of scrophulous nature, is not rare; it is characterised by red plaques, indurated,

me several instructive cases. I have also had the opportunity of examining several subjects of the malady, who have been presented by different members of the Dermatological Society at its meetings. I have also seen cases in the Paris hospitals, and one excellent example under Professor Neumann in the wards of the General Infirmary at Vienna. I make these statements here as a matter of justice to others, and because,

upon which the finger, when applied momentarily, makes the redness disappear, to quickly return in a few moments. One feels on and under the skin an induration which sinks more or less deeply into the subcutaneous connective tissue. The redness, more or less dark, pretty often violaceous, more marked at the centre, blends insensibly with the normal colour of the skin. There is no itching upon these plaques; pressure with the finger is hardly painful. This affection is observed commonly upon the legs, more often perhaps in girls than in boys. I have often met with it upon the legs of young washerwomen, in young girls offering all the attributes of the "fraîcheur et embonpoint scrofuleux." The seat of predilection is the external and inferior part of the leg. One sees it sometimes also situated a little above the heel along the tendo Achillis. Lastly, one can observe it also on the face, and I have seen it upon this region alternate with scrophulous ophthalmia.' On page 193 he varies his description with regard to the colouring, and states that the colour is the same upon all the extent of the plaque, the induration is equal, and pressure is painless. At page 501 he records a case in detail, observed in a washerwoman in 1858, and of six months' duration. The lesions did not ulcerate, were not painful to pressure, like those of erythema nodosum, nor was there the play of colours observable in the latter affection. The woman was in hospital for six weeks, and was treated by Tisane of Hop and Syrup of Iodide of Iron, internally; by starch baths, and later by sulphur baths, externally; but was not completely cured on discharge. The year previous, in his 'Leçons sur les Affections Cutanées de Nature Arthritiques et Dartreuses,' 1860, page 98, Bazin also writes thus: 'Scrofulous Erythema manifests itself in patients who have a soft constitution and the lymphatic temperament. It is characterised by a plaque, usually single, of a vinous red, larger than the taches observed in Erythema Nodosum, situated at the anterior or external part of the legs, not painful, constituted by an uniform induration which is limited to the skin, and does not extend into the connective tissue.'"

I venture to propose that these cases should for convenience sake be known under the name of Scrofulous Ulcers on the Legs, or Bazin's Malady. To call them Indurated Erythema, when by far the most marked feature is ulceration, will lead to nothing but misconception. Although Bazin would appear to have observed only the earliest stage of the malady, and possibly failed to connect the ulcer cases with it, yet there can be no doubt that his description, so far as it goes, does apply to the cases with which we are dealing. He is quite correct in what he has written as to the class of patients attacked and the probable etiology of the malady. It is curious, however, that he should deny the implication of the subcutaneous cellular tissue. In this I cannot agree with him.

it is my intention, as usual, in what I am about to write, to keep closely to my own facts.

The reader may find at page 58 of Vol. I. of ARCHIVES the narration of a case of large ulcers, on the leg of a girl, looking like syphilis. Specific history absent. This was a case sent to me by Dr. Dukes, of Rugby, and it differed a little from the more typical examples of the affection, in that only one lower limb was affected, and in that a large ulcer on the back of the thigh had preceded those on the legs. In a paragraph appended to the report of this case I have briefly mentioned a second one, which was under my care at the same time, and in which both legs were affected. At the time that this short paper was written, I was in ignorance of M. Bazin's description, nor did I know that the subject was attracting attention amongst my colleagues either in Paris or at home. As a matter of fact, I believe that the London observations commenced at about that time, those at the Hopital St. Louis somewhat earlier. The conclusion at which I arrived respecting the two cases referred to, was "that the conditions assumed depended upon feebleness of circulation and individual peculiarity, and not upon specific taint." One of the two patients to whose cases I refer, subsequently got quite well under Dr. Dukes' treatment at Rugby; the other, one of the most severe that I have ever seen, did not improve quickly under treatment, and was lost sight of after a few attendances. The reader will find recorded in my little book on Syphilis, at page 351, two very remarkable cases in which adult married women were the subjects of these ulcers, and in which I was much puzzled to decide whether they should be considered syphilitic or not. The cases were under my care in 1885, and one of them has remained so at intervals ever since. My subsequent observation of these and of other cases obliges me to believe that neither of them had any relation to syphilis. Both of them had been pronounced to be syphilitic, and were brought to me with that diagnosis. This, indeed, has been the suspicion in most of the cases that have come under my care. It is, as I have said, the liability to this error which constitutes one of the most important features of the group. In the report to

which I refer (see page 355) I have also recorded a case of a healthy-looking married man aged 54, in whom the history of syphilis was wholly wanting, and both of whose legs were covered with ulcers exactly like those to which I refer. I may remark, in connection with this case, that the patient was very much older than in any other which I have seen. As a rule, the affection is one of childhood or adolescence. A very important point for investigation in connection with these cases is the question as to how far and in what sense they are to be considered as scrofulous. To this it will be seen in the following narratives I have given special attention, not so much, I may admit, by search for the bacillus as by careful inquiry as to family history. In certain cases undoubtedly these ulcerated legs are found in association with other manifestations of a strumous kind, but in not a few no such association can be proved. Although it is quite certain that the local process is an infective one, and that one ulcer becomes the parent of others near to it, yet the escape of the lymphatic glands in the groin is, I think, an invariable and noteworthy fact. In no single case which has as yet come under my observation, have I witnessed the development of any definitely tuberculous affection.

As regards the initial lesion, it is not always the same. I may quote the following sentence from what I wrote in 1887 (see page 355): "I carefully studied the initial lesion in these cases, more especially in that of Mrs. D——. It did not appear to be always the same, consisting in some instances of an indurated knot under the skin, possibly around a vein or lymphatic; and in others of a large and very slowly progressive lichenoid tubercle, developed around a hair follicle. After ulceration had taken place, the sores always tended to the formation of low rupial scabs." It is quite possible that the two conditions mentioned may be co-existent only in the later stages of the disease, and that the subcutaneous knots, which are in all well-developed cases such a marked feature, are really secondary and the result of infection from an ulcerated lichenoid tubercle. When the condition shows itself on other parts of the body, as, for instance, on the backs of the upper arms, it is always in the form of lichenoid papules, and never

attended with subcutaneous knots. I have only seen the face implicated in a single case, and in that the condition was one of ulcerated acne. These facts lend support to the view that the beginning of the disease is usually in the hair follicles and their adjuncts.

The size of the ulcers may vary very much. Usually they are only small, such, for instance, as might contain the half of a hazel nut; but some of them are often very much larger, and may be an inch and a half or two inches across. They clearly spread by infection of their edges, and may thus, if neglected, attain almost any dimensions. I possess four portraits illustrating the condition under discussion, one of them of a child in Dr. Langdon Down's Asylum at Normansfield; one that of Master R——; a third from a patient shown me by Dr. Colcott Fox; and a fourth a Miss ——, who was sent to me by Dr. Hughlings Jackson.* These portraits can all be seen at any time, in my Clinical Museum, by any one interested in the question. I may just remark that several of my patients were girls, who, for epilepsy or other maladies, had taken bromides or borax. On the other hand, in other cases there was no history whatever of the use of any drug of this class.

In my early cases I tried many different methods of treatment, and laid particular stress on confinement to a recumbent posture. I have found, however, that the latter measure is by no means always needful, and I have recently cured several cases while allowing the patient to walk about. An ointment containing four or five grains of the Bisulphuret of Mercury to the ounce is, according to my experience, almost a specific, and exceeds in value all other measures. All drugs which lower tone should be carefully avoided. Tonics and purgatives should be given, and, if possible, the patient should be sent to the seaside. I will now proceed to the narration of some cases which illustrate my general description.

CASE I.—*Ulcers in the legs in a girl—Tuberculous family history.*

The subject of this case was a delicate-looking girl of thirteen. Her teeth were bad in the sense of being decayed and discoloured, but they

* I purpose in my next ARCHIVES to reproduce some of these.

showed nothing suggestive of inherited taint. The upper incisors in particular were large and well formed. There were some enlarged glands on each side of the neck. The child was the youngest of a family of nine, of whom only four were living. There was suspicious history of tubercular developments in several of her relatives. She herself had never been strong. She had many ulcers on both legs. They were exactly of the character of those described in the other cases. Their location, size, &c., are well shown in a sketch taken by Mr. Swainson. Those on the back of the legs were ragged with undermined edges, and presented appearances which would at once suggest the diagnosis of specific disease. It was said that the ulcers on the legs began four months ago.

### Case II.—*Ulcers of the legs in a girl—History of a former attack.*

I saw Miss S——, a girl aged 16½, in September, in 1891, in consultation with Dr. Brockwell and Mr. Gandy. She was of a fair, florid complexion, and had a feeble circulation, but was not liable to chilblains. She was suffering from ulcers on the legs, of which wide undermining of the edges was the chief characteristic. There was a large scar on one leg; quite sound, but with a red edge at one part. The skin of the legs and the subcutaneous tissue were rather thick and pale. The sores were believed to have arisen from midges' bites, and had been made worse by standing. Four years previously she had had a similar attack, and had got quite well. Rest on her couch, a mercurial ointment, and the india-rubber bandage were the measures adopted, and were quite successful.

### Case III.—*Cachectic Ulcers in the leg of a young lady—Prolonged previous use of bromides.*

Dr. Hughlings Jackson was kind enough to send to me a young lady who had been for long under treatment for epilepsy, and in whom unhealthy ulcers on the legs had recently formed.

Miss L—— was 21 years of age, well grown, and of healthy aspect. She had suffered from epilepsy for some years, and taken bromide of potassium, on and off and in varying doses, almost the whole time. She was still taking it. It had not wholly controlled the epileptic tendency, but it had not in any way disagreed, so far as could be observed. She had never had any bromide-acne or other eruptions.

The ulcers on the leg were three in number and all on the lower part of the left leg, but at some little distance from each other. The largest, which was as big as a florin, deep, with abrupt edges, and all but phagedænic, was on the back of the leg. One of the others was in front, and one on the side. The intervening skin was quite healthy and uninflamed. The condition of the largest of the ulcers is well shown in a portrait which was taken. It was almost exactly like that present in Dr. Dukes' case, published at p. 48 of Vol. I. of Archives.

I was obliged to advise in this case that the bromide should be given up, as it seemed very possible that it might be reducing the vitality of the tissues. Dr. Jackson very reasonably protested that the bromide was given at the Hospital for Epilepsy by the pound, and that no cachectic ulcers on the legs were ever observed in consequence of its use. He, however, consented to the substitution of borax.

On February 7th I gave up the prescription of borax, and prescribed nepenthe in miij ter die., and nux vomica with cascara. The sores were dressed with a mercurial ointment.

In March the leg was wonderfully better: one sore being healed, and the others covered with florid granulations.

I subsequently saw this young lady in lodgings at Southend. She had much improved in general health, and the only remaining ulcer on the leg was almost healed. The bromide had been entirely disused for some time. No fresh epilepsy had occurred, but her mother thought that she was threatened. I do not know the final result of the case, not having seen the patient for several years.

### Case IV.—*Unhealthy Infective Ulcers on the legs of a young woman in good health—Cure.*

A remarkable instance of the kind of sores which I have been describing occurred in the person of a very healthy young lady, who was brought to me by Dr. H——. She was twenty years of age, and, excepting that she suffered from cold extremities, no departure from perfectly good health could be made out. She was of active habits and cheerful disposition. Her mother gave me a full account of her life history. She had suffered from typhoid fever eight years ago, and from measles six years ago, but no special ill consequences had followed either. On June 24, 1889, she went to a cold swimming bath in London, and was, she believed, bitten by some insect. Several little irritable tubercles formed, some on the backs of her arms, one on a shoulder, and three on the left leg. With the exception of those on the leg, all had disappeared before I saw her. Those on the leg had passed into peculiarly unhealthy looking ulcers. I saw her first on September 18th, just about three months from the beginning. During the interval, various very judicious measures had been adopted, both local and general, and amongst them a visit to the seaside. Dr. H—— had prescribed iodoform, and under its influence the sores had looked at one time as if they would heal; a relapse had, however, occurred. When I saw Miss R—— there were three sores close to each other upon the front of the right leg. They had swollen and rather livid edges, and their surfaces were destitute of granulations, and covered with grey secretion. They were none of them bigger than sixpences, and it was their peculiarly indolent and unhealthy character, rather than their size, which attracted attention. I was told that in the first instance there had only been one, and thus it appeared probable that something of the nature of an infective process was at

work. Dr. H—— and I agreed to have the sores cauterised with the acid nitrate of mercury, and to insist on the legs being rested in an elevated position. After a fortnight of this treatment, however, not the slightest benefit had been obtained. On the other hand, two little indurations had formed in the adjacent skin, which were threatening to break down into new ulcers. I now recommended that Miss R—— should again be taken to the seaside, and that the use of liquor arsenicalis should be tried as an application in conjunction with complete rest. I also prescribed small doses of mercury internally in combination with tonics. We were already using mercurial ointments, and carefully keeping the foot warm.

At a subsequent visit I wrote: "I feel quite sure from what I have seen to-day that the nature of the process in Miss R——'s legs is an infectious inflammation of the cellular tissue. Near the margins of the ulcers flat areas of redness with slight swelling form, in the centre of which, after a week or ten days, softening takes place. The place finally ulcerates, and then a thin yellow patch of necrotic cellular tissue is exposed. This is the condition present to-day in a new ulcer which has formed during the last week. Whilst it has been forming the old ones have been healing, and some have quite healed, others show healthy granulations. The nitrate of silver, ten grains to the ounce, seems to suit best for the open sores. Miss R—— is staying at Worthing, and is in excellent health. I find that she never took a dose of bromide in her life. The process of spreading by subcutaneous infection seems to be just like that which occurs in cases of diabetes."

### Case V.—*Multiple Ulcers in the legs in an adult male—Feeble circulation—No syphilis.*

A patient who was brought to me by Dr. Barlow in November, 1892, offers another example of these peculiar ulcers in the legs, and one in which they occurred under somewhat exceptional circumstances. A Mr. H——, a gentleman from Yorkshire, aged 36, knew of no other morbid inheritance in his family excepting that of gout. From gout his grandfather and several of his uncles had suffered repeatedly. His father, who came with him, was a hale man of 70, and had never had gout. Mr. H—— himself had, at the early age of 28, or sooner, become the subject of Dupuytren's contraction of the palmar fascia. This contraction had developed almost to an acute affection, and his little and ring fingers, first in one hand and then in the other, had been drawn down into the palm. Some operation had been done in the left hand, and it had resulted in the amputation of the little finger.

When aged 30, Mr. H——had suffered from troublesome inflammation about the right ramus of lower jaw. A succession of abscesses were opened, and of these all that now remained were some long, perfectly sound scars. Mr. H——, although a vigorous man, and formerly an

active football-player, had always been liable to suffer from cold in the extremities and feeble circulation. He had never had chilblains. He had never had actual gout, nor anything definite in the way of rheumatism, but the last joints of several of his fingers were very definitely enlarged, and in one of these was a slight displacement. Dr. Barlow told me that when he first saw him in 1886, his aspect suggested an unfavourable opinion as to his prospects; and he still looked puffy and pale, though he was not definitely ill.

I now come to describe the conditions for which I was consulted. During the last two years, Mr. H—— had suffered from troublesome ulcerations on his legs. His left leg had been first attacked, and had got well, numerous scars being left. His right was still affected, and showed two ulcers exactly like some of those which I have described in the preceding cases. One of these was large enough to hold a half-walnut: it had overhanging, ragged edges, and a general condition so unhealthy as to be suggestive of phagedæna. It would certainly have been taken in former days, from its appearance only, as conclusively syphilitic. There was, however, no history of syphilis, and, as I have said, the ulcer did not exceed in its suspicious characters several others which I have described in cases in which the negative evidence was yet more conclusive than in this. Mr. H——'s legs were not œdematous, but they were thick and somewhat shapeless from excess of cellular tissue, in this respect resembling the legs of young women who suffer from feeble circulation, more than those of a man.

It should be noted that he had an excess of subcutaneous cellular tissue generally. There were a few, slightly marked, small varicose veins on his legs, but nothing of any importance. Near the root of his penis, attached to the fascia of the right corpus cavernosus, there was a very hard lump as big as a horse-bean, probably a calcified phlebolith. It gave him, he said, no inconvenience, and he knew not exactly how it had formed.

We have in this case, I think, an example of a definite partnership between gout, scrofula, and feeble circulation. Although there was no known history of tuberculosis in the patient's family, yet the attack of ophthalmia in childhood, and the abscesses about the jaw at the age of 30, were probably of a strumous nature. As such, also, I should regard the ulcers on the legs. The explanation of the contraction of the palmar fascia and of the acro-arthritis are to be found in the inherited liability to gout.

### Case VI.—*Ulcers on the legs and arms in a child—Inherited Syphilis suspected, but doubtful.*

Dr. Langdon Down brought to me a girl ten years old, who was under his care, as a speechless idiot, at Normansfield. She had in early infancy suffered very severely from convulsions. Although she was well grown, and could use her limbs fairly, she was quite unable to speak. It had been supposed that she was the subject of specific disease, but of this I

could find no evidence. Her teeth were perfectly well formed. Through the whole of her life she had at intervals taken bromides very freely. Quite recently her general health had failed, but until within the last few months, Dr. Down assured me that she had been florid and in good spirits. She was brought to me on account of what had been considered subcutaneous gummata on her legs and the backs of her arms. These had been present during the last six months. It was thought that they had already been benefited by the internal use of mercury, but her legs were still covered with sores. I had a portrait taken of the legs, which I now copy [see next number of ARCHIVES], and which will enable my readers better to realise their state than any description which I can give. They were covered with small ulcers, many of which were still crusted over. Some of them presented, more or less, a papillary growth. There was little inflammation of the intervening portions of skin. On the backs of the upper arms there were a few little lichenoid pustules and one or two ulcers, with a certain amount of papillary growth. The conditions differed a little from those most usual in this class of case, in that the ulcers in many cases presented a raised surface caused by granulation growth. In this respect they reminded me much of the conditions consequent on the bromides and iodides, and were less suspicious as regards tuberculosis. I thought it very likely that the case was complicated by depraved nutrition consequent on the drug treatment.

CASE VII.—*Ulcers on the legs, in a young lady, resembling Syphilis—Some suspicious facts in her history, but final diagnosis negative.*

A case which was unusually perplexing presented itself on November 19, 1890. Miss B——, a very tall, good-looking girl of 16, looking like 19, had both legs covered with ulcers and scars. The ulcers were some of them deep and punched out, and the scars had pigmented edges. Altogether the legs might have been deemed typical of syphilis. She had also some thickening over the shins, and the bone appeared to be distinctly tender. I am prevented from speaking with certainty on this point, because there was some swelling of cellular tissue, and she was rather hyperæsthetic. She was the only surviving child of seven. In further confirmation of the suspicion of inherited syphilis, she had twice been laid up with inflammation of her eyes—once when æt. 6, and a second time æt. 10. Of these attacks all traces had disappeared.

Miss B——'s front teeth were of good form; some of the others showed stomatitis changes. Her forehead was a little suspicious, but her complexion, as already stated, was clear, and showed nothing peculiar. She had always suffered much from cold extremities, and the cheek coloration was circumscribed. On the backs of her upper arms were many little scars, the results of small ulcers from acne (cacatrophia

folliculorum). There were also, both here and on the backs of the forearms, numerous little subcutaneous abscesses of an indolent character.

Her mother stated that as a baby she was quite healthy (but took Steedman's teething powders). Until six years old she was quite well; then occurred a three months' attack of inflammation of both eyes.

Of the six infants which had died, all are said to have suffered in the same way from jaundice; "all became the colour of an orange within a few hours of birth." Three lived only three days; the other three lived a few months. In three of them autopsies were performed, and the doctor said that they were exactly alike—"enlarged liver." Two of the three which lived longer suffered all the time from diarrhœa and other affections. One recovered perfectly, and died, after a few days' illness, of inflammation of the lungs, æt. 13 months.

Both parents are living, and neither have had any special ailment, excepting asthma in the mother. The mother has suffered from childhood from recurrent herpes inside the lips and on tongue.

Miss B——'s eruption began by small spots on the backs of the arms six years ago, and a year or two later ulcers on the legs showed themselves. At one time she had an ulcer on the right leg as big as the palm of a hand, and which her surgeon describes as a sloughing ulcer. Menstruation began only eighteen months ago. She never had a chilblain.

Careful examination of the eyes after atropine did not reveal any traces of keratitis or of choroiditis. Some small opacities at the edges of the cornea made it probable that the attacks of inflammation of the eyes had been of a pustular character.

In March, 1893, I heard from Miss B——'s surgeon that she had completely recovered. Specific treatment had been tried, but proved useless; and improvement had begun soon after calcium sulphide was given. She got quite well after a few weeks, and had remained so ever since, with the exception of a few spots in the following spring. There had also been an eruption of a few papules, which had not broken down, and were going away at the time he wrote.

### Case VIII.—*Multiple Ulcers on the legs preceded by Vesications—History of three attacks—Gland-Struma.*

A girl whom I saw with Mr. Gervis, of Haverstock Hill, presented a good example of the kind of ulcers which I have described, and in association with conditions implying definite struma. She had a considerable mass of enlarged glands in the right side of her neck. On my noticing these, her mother at once showed her own neck, which was scarred by gland abscesses, from which she had suffered in early life. No trace of enlargement (in the mother's neck) now remained.

Miss G—— was a fair-complexioned, well-grown girl of 17, with rather an excess of subcutaneous tissues. The backs of her upper arms were rough with enlarged follicles, but did not show any sores. Both her

legs were, however, covered with small ulcers. Many of these had unhealthy greyish bases, and somewhat undermined edges. There was but little inflammation of the surrounding skin. Mr. Gervis, in his letter to me, had styled them "pemphiginous ulcers," and this expression may suitably indicate their character and abundance. I was told that this was her third attack during the last two years, and that on former occasions they had proved very troublesome, but had finally, after some confinement to bed, healed. The intervals of soundness had not been long. The present relapse had occurred two months ago, and was the worst that she had ever had. Under restriction to bed, however, Mr. Gervis assured me that improvement was already commencing.

In January, 1892, Dr. Gervis was kind enough to report to me that, under the mercurial ointment, all the sores had healed; but that the scars were looking unhealthy, and as if they might break out again. There were a number of small vesicular-looking spots over the leg, which died away and did not develop into fresh sores. They had an inflamed margin, which became dry and left a scurfy appearance. The whole skin was in the condition known as "goose skin." The general health was very good, and the glands in the neck were smaller. Menstruation had always been quite regular. Treatment with cod liver oil, steel, and quinine was still continued.

(*To be concluded, with illustrations.*)

## ON CANCER AND NEW GROWTHS.

(*Continued from Vol. IV., page* 65.)

### *On the Early Diagnosis of Epithelial Cancer.*

I will venture a few remarks on the diagnosis of Cancers which begin on or near the surface, for the most part varieties of Epithelioma. We rarely see them until ulceration has set in, and the problem before us is, usually, to distinguish them from common inflammation, from papiloma, from lupus, and from syphilis. Of these the last is by very far the most important, whether we regard its frequency or the closeness with which it simulates malignant disease. Nine-tenths probably of the mistakes in the recognition of epithelial cancer are made by mistaking for syphilis an ulcer which is really malignant. A few errors of a converse kind are made, but they are of infrequent occurrence, and of trivial ill consequence, whereas errors in the former direction are of every-day experience, and often lead to fatal results.

Growth and ulceration co-existing, that is growth followed by ulceration, are the conditions by which we chiefly recognize epithelial cancer. The points to which we should chiefly attend are these: Is there proof not merely of inflammatory infiltration or of granulation masses, but of something which deserves the name of growth, whether infiltrating the base or sprouting up from the edges, and is there with this a tendency on the part of the new product to break down and die? These are the questions which we have to decide. If we can feel confident in these, we have usually made our diagnosis. The disease is cancer. I put aside a number of minor symptoms, such as the state of the surface, the pain caused or its absence, the state of the lymphatic glands, and say, simply: Convince me that there is growth with ulcera-

tion, and I will not ask for more upon which to base my recommendations. The other symptoms as often hinder as help. More especially permit me to denounce the imbecile habit of trusting for guidance to the state of the lymphatic glands. In syphilitic tertiary ulcers the lymphatic glands are not enlarged, but in cancer they are—so say certain text-books which ought to know better. The fact is, of course, correct; the absurdity—I had almost used a stronger word—lies in suggesting that the practitioner should wait until the glands are large before he ventures to make his diagnosis. If he so waits—and many do—he delays his treatment until it can scarcely by possibility be of use. We must make our diagnosis of cancer before we have any help from the state of the lymphatics, or we are indeed blind leaders of the blind.

*Rodent Cancer of the face beginning at the age of fourteen—History of the same disease in the father of the patient.*

The subject of the following case was a young man of twenty-five, who had a well-characterized rodent cancer on his cheek and the side of his nose. Two operations had been done before I saw him. The patient was subsequently admitted into the London Hospital, where my son excised the disease and did a large transplantation of skin. The diagnosis was fully verified by the microscope. The following notes describe his condition when he consulted me:—

The right side of his nose, and the adjacent part of his cheek and lower eyelid, as far as the level of the outer canthus, are occupied by a superficial ulcer, which presents in several parts a sound, smooth cicatrix. The ulceration involves the inner canthus, and passes downwards on the side of the nose to within a third of an inch of the edge of the ala. The edge of the ulcer is not quite continuous, being broken by healthy scar at several parts. The ulceration is deepest at the lower part of the ala. At the deepest part the ulceration has a sharply marked edge, and is an eighth of an inch in depth. Its surface at this point presents a greyish secretion and is unhealthy. At most other parts the edge of the ulcer

is simply a slightly marked sinuous roll of induration, with scar on the one side, and healthy skin on the other. By this I mean that there is scarcely any ulceration. The disease, for the most part, consisting in an advancing border of growth which is followed immediately by scar. The character of the induration, and its being made up of little crescentic portions which have coalesced, is quite characteristic of rodent cancer. The interesting points are that the disease began at the early age of 14, and was, according to the young man's description, at the age of 20 well characterized and considerably advanced. It is further to be added that his father died of rodent cancer which had eaten away the greater part of his face, and had been in progress thirty years. He was 69 when he died, and, according to him, the disease must have been considerably advanced before his son was begot.

This case is a striking illustration of the general law, that if cancerous action manifest itself in young persons, it is usually hereditary. That form of epithelial cancer, which was formerly known as rodent ulcer, is very common in old age, and may happen to those in whom there is no family proclivity. It is very unusual in those under 30, yet we have here an instance of its commencing in some sort at 15, and being quite well characterized at 20. The subject of the case was the son of a man who had died of the same disease, and he was born at a time when the disease had already been present in his father for many years.

The next case illustrates the same point.

*Rodent Cancer beginning almost from childhood, with history of Cancer of the Scalp in the patient's mother.*

A woman named D——, aged 42, who came to me from L——, with a rodent ulcer on her left cheek, gave the history that she had had a sore or wart almost from childhood. It had been an open ulcer for twelve years at least, and had been called lupus. It had been several times operated on.

It was a well-characterized rodent, with some masses of firm fungating granulations. Her history was that her mother had died of a malignant ulcer in her scalp, æt. 70.

*Proposed rule for prognosis in cases of Cancer suited for operation.*

Mr. Thomas Paget (of Leicester), writing in February, 1850, suggested as a rule in the prognosis of cancer cases that the chance of relief from operation is in inverse ratio to the rate of progress previously shown by the disease. There is of course much truth in this, but at the same time there is an important fallacy. The rule cuts both ways. Slow-growing tumours are precisely those in which operations may with comparative safety be avoided altogether. Thus a slow-growing scirrhus in an elderly person may not infrequently be left, without interference, in the confident belief that it will not shorten the patient's life. The greatest triumphs of operative surgery in cancer occur in cases in which the operation is done early for the growths which are rapidly increasing. Of such I could mention many examples.

*Tumour of ten years' growth in the Orbit of a young man.*

Mr. T. Paget, in illustration of the surgical rule above referred to, records a very interesting case in which he removed a large tumour from the orbit of a young man aged nineteen. The tumour had been growing for ten years, and had pushed out the eye, so that, as stated, it was three inches in front of its natural level. Mr. Paget emptied the orbit, and states that "all present concurred in the malignant nature of the tumour, which now forms a specimen in our museum (bottle 47)." * This patient was alive and quite well five years after the operation. Now taking the fact of ten years' growth and five years' complete immunity after its removal into due consideration, it is certain that the term "malignant" in this case must be accepted with some reservation. A growth of cavernous and fibroid structure is met with occasionally in the bottom of the orbit in young persons, which causes proptosis in the manner described by Mr. Paget and which is not malignant. I possess an excellent drawing

* Mr. Paget's case interested me so much that I inquired at the Leicester Hospital whether bottle 47 could be found, with a view to further examination of the tumour. Unfortunately it is not forthcoming.

of such a growth from a case apparently quite parallel to Mr. Paget's. In it also the patient was a young man, and the tumour had been growing slowly. If, however, we reject this case as no illustration of Mr. Paget's rule, since probably the tumour was not malignant, we can by no means do the same with the following.

*Long immunity after Excision of the breast in a late stage.*

Amongst the other cases mentioned by Mr. Paget in illustration of his statement that tumours of slow growth are peculiarly favourable for removal, he gives that of the wife of a surgeon, the subject of cancer of the breast, who had for some years concealed her disease. "The scirrhus tumour, when I saw it, had attained such a size and state as together with a large axillary gland made the operation one of the boldest steps I ever advised in this disease. The length of time, however, gave me courage; an extensive excision was made, the wound healed, and she lived in comparative ease an active life for twelve years." The death was finally with signs of internal cancer affecting the pleura and some nodules in the skin.

This is certainly a very encouraging case, and may very properly be allowed weight under parallel circumstances. We come, however, I think, to the common-sense conclusion that in the main the rate of progress in the past is often a good criterion of the probable rate of progress in the future. This applies whether an operation be done or not. In favour of operations in late cases, however, and supporting Mr. Paget's suggested rule, we have the important law that the growth of tumours resembles the increase of population, and is fastest in those which are largest. Thus, a tumour which may have taken a long time in arriving at a certain stage, may take a comparatively short one in completing its career.

*Melanotic Growths on the Thoracic Organs of a Horse*
(Plate XCV.)

The parts represented in the appended Plate are the thoracic viscera of a horse. I have copied it from an illustration in the "Veterinary Record" for 1846 by Mr. J. Veson.

My object in reproducing it is to illustrate the wide diffusion which melanotic sarcoma finally assumes. In Mr. Oliver Pemberton's work on Melanosis some not dissimilar illustrations will be found, taken from the human subject, and most of our museums contain specimens demonstrating the same facts. I do not, however, know of any which exhibit them in quite such a graphic manner as does the engraving which I have here copied. It will be seen that the visceral pleura is covered with black nodules of various sizes, perfectly smooth, and many of them quite isolated and without any infiltration of the parts on which they grow. Most of them are sessile, but some are arranged like bunches of grapes. The record of the post-mortem states that the parietes of the chest, especially near the attachment of the diaphragm, was studded over with jet black tumours exactly like those here shown. The liver also contained melanotic growths, and there were many tumours on the external part of the body. It will be seen that the heart itself and the pericardium are apparently free from disease. The mass represented between the heart and trachea is described as a tumour, and had not improbably sprung, in part at least, from the mediastinal glands. The subject of the case was an old grey horse. The symptoms displayed during life had been supposed to be those of heart disease, attended with great distension of the veins of the head and neck. No search appears to have been made for the primary growth. This, no doubt, had been on some part of the surface, and very probably near to the anus; this being the common site for melanotic moles in grey horses.

*West, Newman, lith.*

# DISEASES OF THE NERVOUS SYSTEM.

## No. L.—*Notes on Rigors and Perspiration.*

It might be well worth while to study in some detail the conditions under which liability to shiver and to perspire occurs independently of the ague poison. In the ague paroxysm, and in the rigor of pyæmia, which closely resembles it, there is first a period of arterial spasm, attended by pallor and lividity; after which follows a sense of surface-heat which is finally relieved by perspiration. These constitute the well-known cold stage, hot stage, and sweating stage, and they are probably essential parts of all rigors. They may vary so much in their duration that it is quite possible that in some cases the first and second stages may be wholly overlooked, and perspiration may be the only one noticed. This probably occurs when persons describe themselves as "liable to break out into perspiration on any slight nervous shock." A narrow escape from being run over in the street, for instance, may within a minute or two be followed by perspiration, and the fact that this was preceded by first a sense of chilliness and then one of great heat, may, on account of the short duration of the phenomena, be entirely overlooked, if the person be not very carefully self-observant.

In some persons, out of tone, the act of digestion, especially in its earliest stage, is productive of a tendency to rigor. Possibly most persons feel a little chilly after a full meal, especially if it has been taken quickly and if no diffusible stimulant have accompanied it. Special complaint as regards this symptom is sometimes made by patients. I have in my mind the case of an old gentleman (Mr. H——),

who used to complain bitterly that after his meals he was liable to shiver and to sweat. He was in a condition of senile want of tone, and had a weak heart and some disease of the arteries generally.

In reference to the function of perspiration, we may note that definite changes take place in many individuals at different periods of life. As a rule, children and young persons sweat more easily than adults, and the latter more than the aged. Many persons who in youth perspired freely, cease to do so when age advances, excepting under very unusual conditions. Now and then, however, this general law is reversed. I think it may be asserted that the liability to sweat easily and profusely, if shown in an adult or aged person, is usually indicative of want of tone.

A Mrs. K——, aged 52, who had suffered from nettlerash, and who was liable to erythematous patches on her hands, complained much of very profuse perspiration. She attributed her eruption to the irritation caused by sweating. She was accustomed every night to wake in a profuse perspiration, which was always followed by extreme coldness of the legs. She was much out of tone, and felt weak and tremulous. Her first attack of urticaria had followed a chill, five or six years ago. She told me that as a girl she had been troubled with a hot, dry skin, and could seldom perspire. Her menstruation had ceased entirely four years before I saw her. I believe that she had lived rather freely as regards beer and spirits.

### No. LI.—*Inability to perspire—Ague—Turgid veins over whole body—Subjective coldness.*

Mr. W——, aged 50, from Y——, had never been strong since childhood, and had always been a small eater. He had had rheumatic fever twenty years before; and sixteen or seventeen years before he had had severe intermittent fever. There had been no subsequent attacks. He had always lived in Y——, and had never been specially exposed to malaria. Four years ago he had had sudden swelling of the legs, and he had had also two attacks of vesicating erysipelas on the face. When I saw him his tongue was fissured; and his

venous system over the whole body, legs, arms, and head, was turgid. He complained very much of cold, especially at the back of the neck, and was cased in flannel. His left eye was defective, but the ophthalmoscope revealed nothing. He was liable to unexplained difficulty of breathing; and in hot weather the soles of his feet often became red and tender. He had always been a dry subject; and had ceased to sweat at all lately. He always felt hot and dry. He had taken to riding in the hope that it might make him perspire, but a few drops on his forehead was all that he could ever get. His hands were liable to burn, but he never got them scaly or red like his soles. When he had the ague he "sweated fearfully," and the same occurred on another occasion during an illness. The bowels were generally open; but he was more liable to constipation than to diarrhœa.

## No. LII.—*A peculiar form of generalised Ache in the Teeth in association with defective tone.*

There is a very peculiar form of toothache in which all the front teeth ache a little, or rather in which they all feel as if set on edge. It occurs in connection with defective tone, and perhaps as a symptom of gout. It happens sometimes when tea has been taken in excess to get rid of headaches. The liability may last a few days or a week, or more. The ache is in the teeth themselves, not the jaw, and the front teeth only are affected. The ache is not severe; it is more a sort of mild setting on edge than aching. Everything which might tend to set on edge in an ordinary way becomes intolerable, and sometimes the squeaking of a pen in writing cannot be endured. I have known those who could not use quill pens on account of the liability to this kind of toothache, and one or two who for a while were obliged to desist from all writing.

## No. LIII.—*Paraplegia from Tuberculous Pachymeningitis—Death in the fourth year.*

Volume X. of the Transactions published by the Royal Academy of Medicine of Ireland contains, as always, some very valuable papers. Amongst those which have especially

interested me are one on a case of Endothelioma of the Lesser Omentum, by Mr. Conolly Norman, and one by Professor Bernard on fractures of the carpal end of the radius. There is also an able and very practical paper by the Editor of the volume, Mr. William Thomson, of the Richmond Hospital, on Enterotomy and Colotomy. Professor Birmingham records a case of unique malformation of the heart, with woodcuts. It may be noted that a condition of cyanosis did not save the patient from a rather rapid attack of pulmonary phthisis. Dr. Bewley describes a case of chronic, tuberculous, spinal pachy-meningitis, which is very valuable on account of its completeness as well as from the great rarity of that form of disease. This case is of such interest that I venture to reproduce it in the space-for-time schedule form.

*Pain in the back, followed by paraplegia, which was complete in six months—Paraplegia permanent—Death at end of fourth year from tubercular meningitis—Tuberculous disease of vertebræ and pachy-meningitis of theca—Patient a man aged* 41, *previously of good health.* (Dr. Bewley's Case.)

| DATE. | DETAILS. |
|---|---|
| 1887 | April:—began to suffer pain in lower part of back; worse at night. He continued at business. In July, defect of perception in treading and difficulty in walking. Admitted into hospital July 12. Defective sensation and inco-ordination, but no loss of power. |
| 1888 | Absolute paraplegia. Reflexes excessive; sudden violent pains darting down legs. Occasional need of catheter, but not often. Lower limbs gradually became acutely bent at all joints. Left the hospital in June. |
| 1889 | At his home in the condition above described of absolute paraplegia. No evidence of disease of the vertebræ could ever be found, although carefully sought for. |
| 1890 | At home paraplegic and with stiffened limbs. Sensation much impaired. Angular curvature in the lower dorsal region became developed in May. Returned to hospital in November with abscess below clavicle. |
| 1891 | Became weaker. Had pyrexia for first time. Died comatose in February. |

Autopsy.—Tubercular meningitis of brain (acute). Old pachy-meningitis of cord and disease of vertebræ.

The post-mortem showed the spinal canal of good size everywhere. The tenth dorsal vertebra was soft and carious, and around the theca, in the dorsal and lumbar regions, was some soft, putty-like material. The changes of greatest interest were, however, inside the dura mater. From the third cervical downwards the dura was lined by a soft membrane, which became in the lower dorsal region thick and tough. At this part, but not elsewhere, it firmly adhered to the visceral arachnoid and pia, which were themselves much thickened. The membrane was a quarter of an inch thick on the front and sides of cord, and had compressed the latter to half its normal size. In the lumbar region the false membrane gradually thinned off, and at the lowest part of the canal the thecæ were quite healthy. The brain showed acute tuberculous meningitis, which had been the cause of death.

No. LIV.—*Abortive treatment of Syphilis—Success—Early symptoms of Tabes* (?) *in eighth year.*

Mr. P——, aged 24, who had previously been under my care for spermatorrhea, consulted me on September 9, 1885, for a well-characterised hard chancre. We began mercurial treatment at once, and he never had any secondary symptoms whatever. The treatment was continued for about six months. He married in 1892, being then in excellent health. In 1893 he came to me on account of pains in the lower limbs, which might possibly be the beginnings of tabes. He said that he had "half-minute pains, coming on in a jump," in his legs. He complained also that he was liable to become giddy if he danced, and that very small quantities of stimulants made him uncomfortable. There had not at any time been any symptoms indicative of tertiary syphilis. His knee-jump was good, and his pupils fairly active. He had very troublesome constipation. I contented myself with treating the case as one of marital neurasthenia, and gave him the proper cautions. At the same time I could not avoid suspicion that the symptoms complained of might prove more serious. Whilst the predisposing cause of tabes is in my experience syphilis, the exciting one is usually sexual indulgence.

No. LV.—*Paralytic Mydriasis without other ophthalmoplegic symptoms—Subsequent development of Tabes.*

The special symptom of paralytic mydriasis without other implication of the third nerve was present in the following case. A gentleman, now aged 36, had syphilis when 18, and at the age of 33, whilst in good health, found his right pupil dilated. It remained just as it was when first observed up to the time of his consulting me, three years later. No other indications of implication of the third nerve followed, and in the affected eye accommodation was defective but not lost. The other eye remained all but normal, its pupil being at the time I examined it of the usual size and fairly active. He needed a low convex glass for reading, but could manage letters of No. 1 with the right, and read it moderately well with left (without glasses). This mydriasis had proved to be the first symptom of tabes. Within a few months of its occurrence there was numbness of the ulnar border of the left forearm, and not long after this the front of the abdomen became numb and so sensitive to heat and cold, that he could only wash himself with tepid water. Next there came ataxic pains of both kinds, lightning and gnawing, with entire loss of knee-jerks. When I saw him three years from the beginning he could only just manage to walk without help.

No. LVI.—*Bullet lodged in the head and never removed—Hemiplegia—State of patient four years afterwards.*

I had an opportunity last year of examining the condition of a young man who, four years previously, had had a bullet put into his head, and from whom it had never been removed. The bullet was a small one from a toy pistol, which had been fired inadvertently. A depressed scar in the squamous bone was to be still recognised, marking the point of its entrance. It was about an inch above the right ear. The bullet was believed to have passed obliquely forwards. His history of the occurrence was that he fell immediately, but never wholly

lost consciousness. He lost all power in his left arm and leg. He was in bed for about a month, and catheters had to be used. The surgeon who attended him sought for the bullet, but could not find it. By degrees he regained power in the paralysed limbs, but they were still not so strong as the others. He fancied that they had recently become weaker, but I could not make out that he had much reason for believing so. The calf was smaller and softer than the other. He had of late suffered much from neuralgia across both eyes, and had been wanting in general tone. I was inclined, however, to suspect that these symptoms had more to do with his sexual system and nocturnal emissions than the accident. Both his pupils were very large, the right being larger. His vision in both eyes was perfect, and the optic discs normal. He complained that his left limbs felt numb when he was tired.

## No. LVII.—*On the form of Neuro-retinitis which occurs in Secondary Syphilis.*

A gentleman who consulted me in February, 1892, afforded some facts of considerable interest in reference to the history of syphilis, more particularly as regards the recovery from neuro-retinitis in the secondary stage. In 1887 he had a chancre, and placed himself under the care of a very able surgeon, who gave specifics, but probably not for long. So far as is known no secondary symptoms occurred. The temporary suppression of the disease was so complete that the diagnosis was assumed to have been in error, and ten months after the chancre the patient was allowed to marry. Within a few months of his marriage, however, he suffered from a severe attack of double neuro-retinitis. This was at once recognised as syphilitic, and treated efficiently by several months of mercury. It was a severe attack, and, according to the patient's memory, he was for some weeks almost blind. He finally recovered with almost perfect sight in his left eye, but with a very large central scotoma in the right, which still renders it quite useless for reading, &c.

The history as regards this patient's married life is briefly that his wife, so far as he knows, never showed any symptoms.

She died of acute phthisis about eight years after marriage. Her first three conceptions had ended in premature dead births, but after these three children were born, who did not appear to suffer, and all of whom are still living.

To return to the patient's own case, I may say that I had an opportunity of examining his eyes five years after the attack of retinitis. In his right eye, which was defective, I found the whole yellow-spot region involved in a blur of greyish white. The patch shaded off gradually into the adjacent retina, and there was no trace of pigmentation. Near to it were several smaller patches of a similar kind. They were wholly different from those resulting from choroidal disorganisation. I did not detect any very definite changes at the margins of the disc, and the retinal vessels were not diminished in size. In the other eye I did not find any conspicuous changes. In his defective eye the patient had good peripheral vision, and, excepting that he could not see to read with it, its condition caused him no inconvenience.

No. LVIII.—*Liability to pain behind the lesser trochanter increased in certain positions of the limb.*

When an intelligent surgeon becomes himself the subject of disease there is almost always something to be learned from his observations. My friend Dr. T—— (æt. 52) is much annoyed by liability to pain just behind the lesser trochanter of his left femur. The pain occurs during walking, and comes and goes, and especially is it always brought on, when in bed, by the attempt to rest on the opposite side. He is always obliged to turn back at once. The affected spot is sometimes tender, but I could detect no swelling. The pain does not pass down the thigh like sciatica, but keeps to one spot. It began, in the first instance, after unwonted exertion in walking in Scotland, and was then so severe that it kept him awake two nights. He is of rheumatic tendencies, but has no manifestations elsewhere. He tells me that since he became liable to this peculiar pain he has met with several other persons who suffer in an exactly similar manner. In all whom he has seen the liability to pain when resting on the sound side was a marked feature.

These localised pains are common in gouty persons, and may occur in various parts. They usually follow some slight injury or unusual exertion. Their peculiarity is, as in the case narrated, that the pain is only elicited in certain special positions. In all other positions the patient is quite free. Not unfrequently there is no tenderness, and unless the limb be placed in the one special position, no pain whatever is produced. They are due, probably, to a local inflammation of ligament or cartilage, or in some instances to a local neuritis.

## No. LIX.—*Unilateral Pigmentation.*

Dr. William Ord brought to me a most interesting example of unilateral pigmentation. The condition had been slowly developing during four years on the left pectoral region and side of neck of a girl aged 11. Miss H——, a Jewess, was of fair complexion, but with chestnut-brown hair. She had a remarkably clear and transparent skin. She had not a single freckle on her face; although only 11, she had the growth and appearance of 15. Her left pectoral region was covered with little brown spots, they were limited by a vertical line up the middle of the sternum to the root of the neck, and only very few passed to the right of this line, and none of them to more than a quarter of an inch. From the sternal end of the clavicle, a line drawn to the front of the ear would about mark their boundary on the front of the neck, whilst one passing from the ear down to the front border of the trapezium to the clavicle would limit them posteriorly. They occurred over the whole of the pectoral region to a little below the nipple, and there were two or three very conspicuous scars upon the aureola of the latter. The position and character of the spots will be best estimated by examining the portrait which was taken by Miss Green. There was not a single spot on the back of the neck, nor any on the shoulder or arm. None of the spots were larger than a threepenny-bit, and most of them somewhat less; none of them were exactly rounded. Miss H——'s mother said that the first spots had been observed just over the inner end of the clavicle. She considered that they had been gradually increasing in number and size during the last four years.

No tendency to retrogression had been noticed, and nothing in the nature of scaliness or congestion could be appreciated. The spots stood on an otherwise normal skin.

## No. LX.—*Herpes after a long course of Arsenic.*

Mrs. S—— had been for long under my treatment on account of lupus erythematosus. She had taken continuously from June 2, 1892 to January, 1893, a dose containing one drachm of Solution of Bichloride of Mercury and five minims of Pearson's Solution of Arsenic. In January she came to me with a group of herpetic vesicles on her left temple. A curious feature in the case was that she had a good deal of swelling of the whole of the side of the face and possibly some enlargement of the glands in the upper part of the neck.

## No. LXI.—*Notes on some rare forms of Herpes.*

The family group of herpetic maladies must be considerably enlarged. We begin by the clear recognition of two forms of herpes—common shingles, which may appear on any part of the cutaneous surface, and is usually not recurrent; and H. labialis, which occurs only near the central orifices of the body, and which in those who have once had it is exceedingly prone to recur. We recognise as essential features in both of these, that they are transitory forms of inflammation of the skin, due in all probability to local neuritis, that they are spontaneously curable, and never attended by the production of self-infective elements. The local characters of the eruption are also distinctive and very valuable means of recognition: thus the group of herpetic vesicles is always more or less panniculate or corymbiform in its arrangement, never round nor showing abrupt margins. Its vesicles are never discrete, but are heaped up one upon the other (like mountains, not like mole-hills).

Accepting the general features which we have just indicated as being characteristic, with various modifications, of all herpetic inflammations, we have, next, to include in the family group a number of other cases which at first sight

might not have been recognised as such. Thus, there are many cases of sore throat, sore tongue, and the like, which in their transitory duration, frequent recurrence, and unilateral asymmetry, are clearly herpetic, although from the nature of the structure involved they never exhibit any definite vesicles. Respecting some of these, especially those so common after syphilis, it is not always the fact that the duration is definitely limited. Next, we have cases in which the herpetic vesicles occur on the skin at a greater or less distance from any of the orifices, and in which, whilst in all external features they exactly resemble those of zoster, this most remarkable difference is observed, that they tend to recur over and over again in exactly the same place. Here we have a sort of connecting link between herpes zoster and herpes labialis.

Another group of aberrant forms of herpetic affections is encountered in certain cases in which an eruption on the skin, which closely resembles herpes zoster in the arrangement and formation of its vesicles, is wholly unlike the latter, being generalised, bi-lateral, and persistent. The belief that these cases, in spite of the dissimilarity just indicated, are really and essentially of a herpetic nature is much assisted by the fact that they are for the most part curable and preventible by the same remedy which cures and prevents herpes, that is, arsenic.

It will be seen that our conception of herpes, which was simple and tolerably definite so long as we knew only of herpes zoster and herpes labialis, has become, with the addition of the other forms referred to, somewhat vague and indistinct. We must, however, go yet further, if we would attain to a clear recognition of all that herpes really is. Zoster and labialis must be allowed to serve only as conspicuous sign-posts to attract our attention and induce further search. That the development of vesicles is an accident of the structure affected, and by no means essential to a herpetic inflammation, must be freely admitted. In most cases even of common zoster, parts of the skin which are affected fail to develope vesicles; and in many cases, over the whole of the involved area, although the characteristic pain and redness

are present, the attack ends abortively, so far as the production of vesicles is concerned. On mucous membranes the production of definite vesicles is rare, or they break so soon that they are not recognised, and probably we have many cases in which redness and pain are the only symptoms. Admitting these facts, it is not too much to ask belief to the creed that we may have inflammations of solid structures or of serous membranes, essentially herpetic in nature, but which are quite unattended by the production of vesicles. A local inflammation of neuritic origin, and not a local dermatitis attended by vesicles, must be our definition of herpes.

It has often been remarked that herpes zoster but rarely passes so low on either extremity as to affect the hand or foot. It is often seen on the upper arm, and sometimes on the fore-arm, similar statements being true as regards the thigh and leg: it very rarely, however, passes the wrist and ankle. When it does so, the cases usually present some peculiarity. I have just seen, in consultation with Dr. Morriston Davies, a very remarkable example of recurrent herpes affecting the hand. The patient, a married lady of 28, had, when she was brought to me, a definite group of herpetic vesicles, clustered together exactly like shingles, along the ulnar side of her index finger. There were others, less well developed, in the palm of her hand, in a line with the index. They had been out a few days. The history was that she had been liable to attacks, always on exactly the same part, at intervals during the last five years. They had persisted in recurrence, and, indeed, the intervals had become shorter and shorter in spite of much treatment both by physicians and specialists. This treatment had, I was assured, included a long continued course of arsenic. Mrs. M—— did not consider that her trouble was in any way connected with her general health, for she was never ill. She had borne three children, and during one of her pregnancies, the last, her eruption continued to recur almost regularly, once a month, during the whole time, and she had an attack within two weeks of her confinement. Her first attack had been five years ago, and was less severe than many of the subsequent ones. During the first two years the intervals

had been three or four months, but latterly much shorter. The eruption was attended by much burning, and usually disabled her hand for a week or ten days. It had, therefore, been a great source of inconvenience to her. She had no other form of skin disease, but on one occasion a group of herpetic vesicles had appeared on one thigh and run their usual course.

I have seen a good many cases of recurrent herpes, and they constitute a very peculiar, and probably, if we could understand them, a very instructive group. I put aside for the present those in which the genitals or the lips are affected, since they are very common, and since they do not closely resemble the type of herpes zoster. The class of cases to which I now allude are those which are indistinguishable from zoster in the form and arrangement of their patches. Examples of this are decidedly infrequent; they occur occasionally in connection with diseases of the nervous system, such as tabes (of this I think Dr. Buzzard had recorded a good example), and under these circumstances usually affect the buttocks or upper parts of the thigh. I have had to treat some very troublesome cases in young patients in whom the disease occurred on the neck or cheek: I do not think that I have ever seen recurrent herpes on the more usual position of zoster, *i.e.* the trunk. On some part of the thighs or buttocks, neighbouring the genitals, or on some part of the face or neck near to the mouth, are its usual sites. As a rule, the tendency to recurrence is definitely controlled by the use of arsenic. The case which I have just recorded above was very exceptional to my experience in this respect. I have under care a young lady who has taken arsenic more or less continuously for the last fifteen years, in order to prevent the recurrence of a very troublesome patch of herpes in the lower part of one cheek. Whilst taking the drug she never suffers: but if she leaves it off for a few months, she is almost certain to get a patch. It is a most definite fact that the recurrence almost invariably occurs on the same part. In the case just described it has always been exactly the same nerve-tract in the hand that has been affected. In others the eruption may not recur on exactly the same part, but is still usually so near to it as to make it evident that it is the same nerve-twig that

is affected. Some of the recurrent cases, more especially of course those in association with tabes, have occurred in patients who had previously suffered from syphilis, but in several there has been no suspicion whatever in this direction. There was none, I believe, in the case which I have recorded above.

### No. LXII.—*Case of Morphœa, in which Ivory Patches were arranged in zones, in bilateral symmetry, on shoulders and hips—Symmetry not complete—Much pigment deposit.*

The detailed study of cases of herpes and of morphœa is of much importance in reference to the physiology, and even possibly to the anatomy, of the nervous system. That in a general way the changes of morphœa are distributed through the influence of nerves, much as are those of zoster, is now, I think, generally admitted. There are, however, some apparent exceptions to such a law of distribution, and there are many facts which require painstaking investigation before they can be brought under it. The matter is indeed by no means so simple and easy as it usually is in a case of zoster.

A case, illustrating a very remarkable and exceptional arrangement of morphœa patches, has just been under my observation. The patient was a married woman, aged about 54, in whom the disease had commenced about six months before I saw her. It began, she said, in October, 1892, by a little irritation on the lower part of her back, and almost at the same time she noticed that there were some patches of discoloration on her neck. She knew of no cause for it, and had usually enjoyed good health. About Christmas her skin was so irritable that it made her feel somewhat ill. There had been, in the first instance, a little dry exfoliation. The feature that first attracted attention when I saw her was a diffuse, brown discoloration of the lower part of her neck and upper part of her chest. It was soon noticed, however, that with this there were many streaks or dots of the lardaceous stage of morphœa. These were chiefly conspicuous about the clavicles. On the left forearm, a little below the elbow, there

was a small, oval, ivory patch. With this exception, the upper extremities were free. When she had undressed, I found that a zone of discoloration, upon which indistinct white patches occurred, occupied her hips, buttocks, and upper parts of thighs. Below this, on the fronts of the thighs almost to the knees, there were a number of oval, ivory patches very well characterised. A single small patch of the same kind occurred in front of the left leg. The skin on the whole of the discoloured zones was stiff and rigid; quite different from that of the unaffected parts. Between the diseased zone involving her shoulders and that involving her hips, the skin of the lower part of chest and upper part of abdomen was perfectly healthy. So also was that of her head and face, and, with the exception referred to, of her upper extremities. She was a thin, pale, nervous woman, but her hands did not show the slightest tendency to sclerodermia or to Raynaud's phenomena. Her circulation was indeed good.

It will be seen that we have, in this case as in others, good reason to believe that the changes in the skin were located by the nervous system; for it is not possible in any other way to explain their very peculiar arrangement, nor is it, as I have observed in several other cases, an unrecognised occurrence for the changes of morphœa to be grouped in fair bilateral symmetry. I do not, however, recollect to have ever seen a case in which the changes occurred in definite zones, as in this instance. It will be seen that the chief exception to bilateral symmetry was in the development of a patch on the left forearm and left leg, which had no representatives on the other side. The occurrence of deep, diffuse pigmentation of the integument near to the lardaceous patches was also much in excess of anything that I have seen in similar cases.

## No. LXIII.—*Two Cases of Sclerodermia.*

Dr. Stephen Mackenzie brought to the Dermatological Society on February 9, 1893, two most interesting cases, illustrating the two forms of sclerodermia. Both patients were children.

The first of these, a boy of about 14, afforded an excellent example of what used to be known as "the hide-bound condition." His skin everywhere was stiff, and slightly indurated. This condition was, as usual, most marked on the extremities. Then his fingers were tapered, very pale, and hard as wood: passing up the fore-arms the condition gradually diminished, but did not wholly disappear. The skin of his face was tight, and his features fixed: he said that he could not laugh; he could, however, shut his eyes and his mouth, the degree of induration being only slight. On the trunk the skin, although still slightly stiff, was much less affected; that of the scrotum and penis was absolutely free from even the slightest degree of induration. It contrasted markedly with that of the adjacent parts of the abdomen. The skin everywhere was very white. There was no actual œdema, but it still looked and felt as if it were in a slight degree swollen. The boy looked ill, and his abdomen was tumid. The account which he gave of his malady was that it had come on rather gradually at a time when he was in his usual health, about six months ago. He had previously had an attack of typhoid fever, but he thought that he had well recovered from it some months before any change was observed in his skin. He had just been apprenticed to a wood-carver; he had found the work too much for him, but he assured us that it did not involve any exposure to cold. Before this illness he had not been liable in any special degree to coldness of the extremities, and had been accustomed to mix with other boys on equal terms. Dr. Mackenzie told us that conditions resembling those of Raynaud's phenomena had frequently been observed in his hands and feet, but there had been as yet no approach to gangrenous states. The conditions in this lad were both symmetrical and universal (with the exception of the genitals); the hide-bound condition differed only in degree in different parts, and these differences of degree corresponded exactly in the two halves of the body.

Dr. Mackenzie's second case was one which some observers had regarded as, like the preceding, an example of diffuse sclerodermia. From this opinion, however, I was obliged to differ. The case appeared to me an example of localised

morphœa with an exceptional tendency to bi-lateral symmetry, which, although deceptive at first sight, ought not to be allowed to disturb the diagnosis. The conditions, although severe and extensive, were far from being diffuse and universal, nor was the symmetry exact. It was a case in which the limbs where chiefly affected, the head, face, and neck having escaped. There were numerous and characteristic ivory patches on both extremities, and one, which was small but very definite, on the left side of the abdomen, midway between the umbilicus and pubes. Both hands were bent forwards at the wrist, and there were patches, which appeared to be partially scars, on the backs of both wrists. The skin on the front of both knees was also somewhat excoriated. Over the greater part of all four extremities the skin was tight and indurated, but this was not quite universal, even on those parts, and although very extensive, the changes were arranged more or less in patches and streaks. In marked difference from what occurs in diffuse sclerodermia, the digits themselves, both of hands and feet, had almost wholly escaped, and their skin was supple and soft. The skin also of the girl's face and neck showed no change whatever, and could be easily pinched up into large folds. The same statement is true, with the exception of a few small patches, of the skin of the entire trunk. The duration of the disease in this case was, I believe, about a year. It appeared not at all unlikely that the lower limbs might be disabled permanently. The hands were in a more hopeful state, although somewhat crippled.

Comments.—Although it may be admitted that there are still gaps in our knowledge as to the relationships of the two, yet it may be safely held that the two types of sclerodermia differ essentially. One is always and accurately symmetrical and always affects the hands and face; the other, although it may be bilateral, is very rarely indeed accurately symmetrical, and avoids rather than otherwise the parts named. The one often appears to have some alliance with Raynaud's phenomena, the other has none whatever. In Dr. Mackenzie's two cases we appear to have a good example of each. I have already published many exceptional cases, and shall return to the subject at a future time.

## SYPHILIS.

### No. LV.—*Small-pox and Syphilis.*

During the present wide-spread, though not severe, prevalence of small-pox, it is very desirable that the attention of medical men should be alive to the fact that syphilitic eruptions not very infrequently resemble variola in a most deceptive manner. I have published in past years several cases illustrating this fact, some of them very noteworthy ones. I have repeatedly known the subjects of an acute syphilitic eruption either isolated in their own homes, or sent into small-pox hospitals, under a mistake as to diagnosis. In one of these I felt it my duty to record the fact that I had myself in the first instance been deceived and given an opinion which proved to be an error. The fact is that the syphilitic eruption that resembles variola resembles it so closely, and is often attended at its outset with so much fever, that there is little except the history of the case on which to base the diagnosis. If, therefore, the history be concealed and the primary phenomena have disappeared, it may be often extremely difficult in the first instance to form a correct opinion. As the case advances, and when the eruption is found to persist or to come out in successive crops, the suspicions of the surgeon will generally be aroused. As a matter of fact, even in the early stage, it is but seldom that the observer will be in doubt if once his attention has been directed to the possibility of syphilis. It is chiefly in the cases in which no suspicion is ever felt as to the disease being other than variola that mistakes occur.

During the last few months two cases have come under my observation, presenting difficulties in the direction above referred to. In the first, a gentleman, whom I had myself

treated for syphilis fifteen years ago, came to me with a general eruption which had been out only four days. He assured me that he had been exposed to no fresh contagion, and requested me to examine his penis. I felt sure that such an eruption as he had could not possibly have anything to do with his long-distant syphilis, of which indeed he appeared to to be perfectly cured; and when I learnt that, prior to the appearance of the spots, he had been for two days under his family medical attendant with backache, sleepiness, and general discomfort, I felt sure that we had to deal with a case of modified variola. This diagnosis was subsequently confirmed by others, and although the patient felt well, had normal temperatures, and was very anxious to proceed on a journey to Scotland, we insisted on his isolation. He had been twice successfully vaccinated, and hence probably the mildness of his attack. As regards the eruption, the diagnosis lay between varicella, variola, and syphilis. The latter being excluded, the induration of the pustules at their base, and the fact that there had been distinct premonitory febrile symptoms, made me feel certain that we had to deal with small-pox, and not with varicella.

The following are the particulars of my second case:—

When Mr. T—— came into my room, noticing that his face was covered with scars and stains, I asked, "Have you had small-pox or syphilis?" His reply was, "Both." He at once explained that his syphilis was two years and a half ago, but that he had only just left a hospital in India, where he had been treated for an attack of small-pox. On making him strip, I found that he was covered not only with scars which looked like those of variola, but that he had a number of little shotty tubercles which looked much like variola spots in course of development. Many of these were obviously recent, and he told me that they were still coming out. On asking for exact dates, I found that he had been cured of what he called his attack of syphilis, and which had in all probability been such, by a few months' treatment; and that he had subsequently enjoyed two years of excellent health and entire immunity from symptoms. Then, on February 13th of the present year, he went to a Calcutta hospital to be operated

upon for a fissure of the rectum, being at the time in excellent health and without a spot on the body. Ten days after his admission to the hospital an eruption began to appear, and he had evening temperatures from 101° to 103°. He was confined to his bed, and the eruption was diagnosed as small-pox. Very shortly afterwards ulcers appeared in his tonsils, which required the application of caustic. He was told that he had both diseases together, and that the effect of the small-pox had been to bring into activity his long latent taint of syphilis. On the 10th of March, whilst his small-pox eruption was fully out, vaccination was done on both arms, and two vesicles on each arm rose, as he said, splendidly. Of these large, thickened, and congested scars still remained at the time of his visit to me. In the beginning of April—that is, about a month after the outbreak of small-pox—mercury was ordered, and from this date improvement was steady. When Mr. T—— called on me on May 20th, exactly three months had elapsed since the beginning of his eruption, but he still had grey-edged ulcers in his tonsils, and, as I have already said, his body and limbs were covered with small scars like those of small-pox, and with shotty pustules, which might be either developing small-pox or syphilitic tubercles.

I could make no doubt that he was the subject of a recent attack of syphilis, and having regard to the fact that the vaccination had taken well, whilst he was covered with the eruption which was called small-pox, I thought it probable in the highest degree that he had never had the latter malady at all. A suspicion crossed my mind that such was probably the opinion of his former medical advisers, although they had not told him. It seemed very improbable that they would have vaccinated him unless doubt had been felt as to the diagnosis of variola. Since it was obvious that such an eruption attended by symmetrical sore throat could not possibly be the result of syphilis, which had been apparently cured two years ago, I next directed my attention to the search for a new chancre. It occurred to me as possible that the sore which he had in the anus might have been a chancre, but, on examining his penis and groins, it seemed scarcely necessary to entertain that hypothesis. He freely admitted

that he had been occasionally exposed to risk, and that he was very liable to have abrasions. Although there were no definite remains of a chancre, there were suspicious appearances, and the glands in both groins were hard. Thus I have no hesitation in believing that we have to do with a case in which a second infection of syphilis was attended with a variola-like eruption and high fever. Although there was small-pox in the hospital into which the man was admitted, and a child had there recently died of it, yet he was not aware that he had been exposed to contagion; and the subsequent successful vaccination appears to show conclusively that he had at any rate not taken any.

## No. LVI.—*Narrative of a Syphilitic family.*

Cases, in which several brothers and sisters suffer from inherited syphilis, afford us some of the best opportunities for the study of the laws under which such transmission takes place.

I treated, about five years ago, a married lady for a large glandular abscess in the neck, which I at first thought to be only of a strumous nature. Whilst I was attending her she brought to me her eldest child, a girl of about ten, with phagedænic ulceration of the palate and fauces. I was sure that this could be nothing else but inherited syphilis, and at once altered my treatment for the mother from tonics to specifics. The result was most remarkable, and some very extensive ulcerations in the neck were soon soundly healed. During the last year this lady has been under my care for an acute periosteal node under her left eyebrow. Its suppurated and bare bone is, at the present time, exposed. There can, therefore, be not the slightest doubt that the mother is the subject of tertiary syphilis. The child who had the phagedænic throat, is, as I have said, her firstborn. She is now fifteen years of age, and apparently in excellent health. Her throat, after persevering treatment, healed, though not until there had been very considerable destruction of the parts.

About two years after I had treated the child mentioned, a sister seven years her junior was brought to me with interstitial keratitis and deafness. Her eyes recovered as usual, but she remains, I am sorry to say, almost absolutely deaf. On the day on which I write this (May 9, 1893), a third child in the same family has been brought to me, having suffered from a most severe attack of interstitial keratitis, which has left dense white opacities in the middle of the corneæ, which threaten to be, in some degree I fear, permanent. This youths completes the family, for there are but three, and it will be seen that all have suffered from severe forms of the late manifestation of the taint. There is seven years difference in the ages between the eldest and youngest, and it is thus certain that a mother may remain capable of transmitting the disease to her offspring during the whole of that period; nor can any difference in the degree of severity with which these three children have suffered, be traced. The eldest has had a phagedænic throat, but no affection of either eyes or ears. The youngest has lost her hearing, and has also passed through an attack of keratitis. The middle one, the boy, has suffered from keratitis only.

The narrative which I have just given refers to the same family, the particulars of which are recorded at page 292 of Archives, Vol. II. My chief reason for again recapitulating the facts is that I may complete them by the addition of the narrative of the boy's case, respecting whom I formerly wrote that he had remained, from infancy upwards, wholly without symptoms. As has been said, he has now passed through a most severe attack of keratitis. I may still corroborate what I formerly wrote as to his not presenting any obvious signs of taint. Unless he had developed keratitis, there is nothing whatever to betray his malady. He is a tall, well-grown lad, and his physiognomy, although peculiar, presents nothing suggestive of syphilis. His nose is not in the least sunken, and his teeth are not definitely notched. His upper central incisors are, it must be admitted, peculiar, but they would certainly not in themselves justify a diagnosis. They slant towards each other, and their edges are a little narrowed by rounding off of their angles. As recorded in my former note,

not one of these three children presented any symptoms in infancy, and, so far as I know, neither of their parents in the least suspect the malady from which they suffer. Thus we have most convincing proof that the taint of inherited syphilis may remain latent until near the period of puberty, for the same occurred in all three children. I have not seen the youngest child since her permanent incisors were cut, but neither the eldest nor the second have definitely notched teeth. The absence of peculiarities of teeth and physiognomy, together with the absence of all history of infantile symptoms, corroborates the hypothesis, which I have always maintained, that such peculiarities are the direct results of inflammations in infancy, and must not be expected to be present unless such have occurred.

At the time of my former mention of this family I had not seen the father himself. I have recently done so, and may now say that he appears to be in good health, and that both he and his wife aver that he has had no ailments since marriage. Considering how severely his three children have all suffered, I did not feel myself justified in asking him any questions which might lead to his recognising the cause of their maladies. I am, therefore, not in a position to state the date at which his disease was contracted, or what happened to his wife immediately after their marriage. I must again, as I have done before, ask my reader's attention to the fact that any one of these three cases might be easily, if taken alone, have seemed to afford very strong evidence on the negative side in reference to the connection of the disease displayed with inherited syphilis. Thus, in the case of the phagedænic throat, it might have been alleged that both parents were healthy, and that the brother and sister were wholly without symptoms and well grown. At one period these statements would have been perfectly true, and, since the patient herself was well developed and showed no signs of taint, it might have been plausibly argued that the ulceration of the throat was merely due to scrofula or some other cause. So again, supposing that if, at the time the youngest child came under care for interstitial keratitis, nothing had been known as to her sister and mother, it might have been

urged that there was nothing whatever to justify the diagnosis of syphilis.

Many cases have been placed on record as being exceptional to the statement that well-characterised interstitial keratitis is always specific, in which the evidence, or rather the absence of evidence, is precisely of the kind here hinted at. Let me repeat that not one of the three children had had infantile symptoms, and not one showed, either in teeth or physiognomy, anything that in the least approached the characteristic peculiarity. Yet, when we regard the evidence afforded by the four cases taken together, no one can for a moment doubt that the mother's glandular ulceration, the eldest child's phagedænic throat, the keratitis in the second child, and the keratitis and ear disease in the third, were one and all definitely syphilitic.

## No. LVII.—*Inherited Syphilis severe in infancy, but leaving no traces—Periostitis and Keratitis at puberty—Mother of the patient in excellent health throughout.*

The following notes were handed to me, as introductory to a consultation, by the mother of the patient, and as they state the facts very clearly, I may as well give them in her own words.

"Five weeks after his birth (1881) our doctor declared him to be suffering from syphilis; skin between thighs being deep copper-coloured red; corners of eyes and mouth split, skin on body coming off in strips; snuffles; constant screaming and crying.

"Treated with iodide potassium (ointment and medicine). At six months old was quite cured, and kept well till he was nearly ten years old.

"In April, 1891, had periostitis. Was treated by our own doctor for nearly two years with iodide potassium (ointment and pills), sometimes varied with iodide lotion; all with little or no effect, the pains at times being most acute at night, and aching at all times upon the slightest exertion. Was wheeled about in a long perambulator, and at other times went on crutches.

"In January of this year his eyes also became bad; so in despair I took him to an ophthalmic hospital. They examined his legs as well as his

eyes, and gave him "grey powders." In less than a fortnight the swelling of his legs had gone down a good deal, and all pain and tenderness had completely gone. He can now run and play about with ease.

"He was then treated with mercurial ointment and iron and quinine pills for three months, and has now been told no more can be done for his eyes.

"He is the eldest child."

The boy to whom the notes refer was eleven years of age when brought to me. He was a healthy-looking lad, and there was nothing in his physiognomy or teeth which would have enabled me to recognise inherited syphilis. He had, however, in both eyes evidences of bygone keratitis; and, on the fronts of both tibiæ, there were long and very definite nodes. His teeth did not even show in any marked manner the changes peculiar to mercurial stomatitis, and it is interesting to note in this connection that the mother's account stated that he had been treated in infancy by iodide of potassium only. The case is certainly a good example of recovery, without any apparent damage to tissues, from severe infantile symptoms; at the same time it must be remembered that he has not escaped severe periostitis and keratitis. The ophthalmoscope revealed a few small patches of pigment in the periphery of his choroids.

It is of interest to turn to other facts in the history of this family. I did not see the father, but the mother, who had been made acquainted with all the facts, was herself apparently in the enjoyment of most perfect health. She was florid, cheerful, and looked much younger than her years. She said that she had never suffered the slightest illness since her marriage. Her husband, on the contrary, had always been ailing, and was at present suffering from syphilitic ulcerations. There had been no miscarriages, nor had any of their children died. Our patient was their firstborn; the next, three years younger, and now aged eight, had never shown any symptoms. After his birth, for some years, the husband and wife lived apart; but during the last year another child had been born, now aged seven months, who was in perfect health. All three children were boys.

The evidence afforded by this narrative is clearly in favour

of the belief that a father may transmit syphilis without infecting his wife; and secondly, that he may himself continue to be the subject of tertiary symptoms, and yet have untainted children born to him.

## No. LVIII.—*Eruption on the Tongue of peculiar character nearly three years after Syphilis.*

Mr. C. M. T——, a tall, rather pale man, who lives freely.

November, 1890.—A chancre with double bubo which did not break; eruption and sore throat cured by a two months' course of mercury under Dr. Fair.

1891–92.—Quite well.

March 24, 1893.—A most peculiar eruption on the tongue. There are scattered white specks, or dots, on the front half of the tongue.

The eruption consisted of a number of white dots, twenty or more, scattered with tolerable symmetry over the front half of his tongue, which was partially denuded of fur. They were slightly elevated, and distinctly rough to the touch. They were of the nature of the filmy patch, but were very small—mere dots, and not patches. They had been developed, he said, within the last four months, and, coincidently with them, some scaly small rings had formed on his scrotum. The latter condition made me feel sure that the disease was syphilitic. It will be seen that there had been an interval of about two years since his treatment. I prescribed the solution of the bichloride of mercury in doses of a drachm and a half. This was on March 24th. He came to me again on April 11th, with his tongue so well cured that it was only with great difficulty that I could find the sites where some of the spots had been. All the appearances depicted in Mr. Burgess's drawing on March 24th had disappeared, and any one seeing the tongue for the first time would have taken it for a perfectly normal one.

## No. LIX.—*Pigmented Scars after Chancres in a patient of fair complexion.*

A gentleman of remarkably light complexion (Mr. W——), fair to a degree, is just well of two hard chancres side by side

in the outer skin of the penis. The remarkable point is that the scars which are left are almost black with pigmentum. It is deepest in the centre, not at the edges as is usual in the scars left by ulcers. In this instance there were no ulcers, only long-persisting induration, thus the scar is not where the skin has been destroyed.

I mention this case because in previous writings I have said that pigmented scars occur usually in dark-complexioned persons. It is perhaps noteworthy that Mr. W——'s father is very dark.

## No. LX.—*Acquired Syphilis in a man who had suffered from the inherited form.*

An example of syphilis acquired by a person who was himself the subject of inherited taint, occurred in the person of a surgeon, aged 32, who consulted me on February 14th. This patient told me that his father, who was also a surgeon, had told him that he had suffered from inherited taint in infancy. There was also a history of interstitial keratitis, and it was added that a younger brother had also suffered from the latter, and that this brother showed characteristic teeth. A defect in the evidence was that the patient himself did not show characteristic teeth, nor was there anything in his physiognomy or state of eyes which would have induced me to recognise the inheritance which he asserted. He was the third born in the family, and several had died.

This patient suffered severely from his acquired disease. He had contracted the chancre in September, and I saw him in February, when it was still indurated in a very marked degree, and threatening phagedæna. He was covered by a syphilitic eruption.

## No. LXI.—*History of children born to parents both of whom had suffered from Syphilis.*

A surgeon was under my treatment in December, 1878, for a chancre on his finger. He got quite well, and I saw nothing more of him until 1892. I had then an opportunity of inquiring as to his family. I found that his wife had contracted

syphilis from him, having been infected before the diagnosis was made. She had borne him two children, both of whom had lived, and neither of whom had shown any symptoms in infancy. The elder of these had remained entirely without symptoms up to the present time, and is now aged 9. It will be seen that he would be born within about four years of the disease in his parents. The younger child, a girl, now aged 8, although through her whole life free from symptoms, has, I am told, characteristic teeth. As I have not had myself an opportunity of examining them, I quite hope that this is a mistake, for I have often been assured that teeth were characteristic which I did not myself consider so. It should be stated that two children have been born since the two mentioned, and that they have never shown a single symptom.

## No. LXII. — *Palmar Psoriasis in connection with inherited Syphilis.*

Amongst the cases which Dr. Abraham was good enough to provide for my lecture at the Hospital for Skin Diseases, on Tuesday, May 16, 1893, was that of a girl of eighteen with chronic palmar psoriasis. The patches on her arms were numerous, abruptly margined, and quite dry. For the most part the condition was one simply of peeling, there being little or no accumulation of epidermis. Psoriasis palmaris at this age is of course very infrequent. The girl stated that it had caused her so much inconvenience that she had been obliged to leave her situation as household servant. She was of somewhat stunted growth, and the skin of her face attracted my attention as being peculiarly pale and soft. It was of that silky softness often observed in the subjects of inherited syphilis. Her physiognomy was by no means characteristic of hereditary taint, but it was sufficiently peculiar to induce me to examine her teeth, and we at once found that they were most extensively malformed, and quite typical both of syphilis and of mercurial.

Her upper central incisors were dwarfed and notched, and very defective in enamel. The lower incisors and canines

were small round pegs. The pre-molars were perfect both in form and enamel, and the first permanent molar was in every instance destroyed by caries down to the gum. We next noticed that at the corners of the mouth there were some little scars, that her frontal eminences were more prominent than natural, and that her tongue was extensively bald, and presented some thin, whitish patches. She had had many attacks of inflammation and irritability of her eyes, and was wearing protectives. Thus the diagnosis seemed conclusively established. We were able to carry it a little further, for on sending for her mother, who was waiting, we found that she also had palmar psoriasis and superficial sclerosis of her tongue, and she gave us the history that her daughter, who was her firstborn and the only one that had lived, had in infancy suffered very severely from eruptions, snuffles, and "thrush."

Thus we appear in this case to have a definite example of the so-called psoriasis palmaris, or persisting peeling patches in the palms, in direct dependence on inherited taint of syphilis. I have seen exceedingly few such cases. In asserting that the local disease was due to the taint, it by no means follows that we ought to expect it to prove curable by specifics. Probably the constitutional element consisted rather in a vulnerability of the parts, which rendered them unable to bear the irritation of household occupations, rather than on any direct tendency to inflame when at rest. The same may probably be asserted as to the tongue. The conditions were in both atrophic or desquamative, and were not attended by any thickening. I should therefore regard exemption from local irritation as of far more consequence than the use of mercury, and should much doubt indeed whether the latter would prove of material benefit. Precisely the same reason applies, however, to most of the cases called psoriasis palmaris in connection with acquired syphilis. It is seldom seen excepting in those whose hands have been more or less irritated by pressure.

## No. LXIII.—*Second attack of Syphilis.*

*Indurated chancre. Complete success of suppression-treatment continued for eighteen months. Sore throat the only constitutional symptom. Good health during four years. A second indurated chancre in fifth year. Sloughing ulceration of Tonsils.*

| AGE. | DATE. | DETAILS. |
|---|---|---|
| 26 | 1887 | On December 19th he consulted me for an inflamed and well-indurated chancre, involving the corona and adjacent roll of prepuce. It was five weeks since exposure. Mercury ordered. |
| 27 | 1888 | The sore healed in a month. Hard glands in groins. Excepting a doubtful sore throat no secondary symptoms occurred. He continued mercury through the whole year (two grains of grey powder three times a day). |
| 28 | 1889 | Is quite well. |
| 29 | 1890 | Quite well. No reminders of any kind. |
| 30 | 1891 | Quite well. No reminders. |
| 31 | 1892 | Came August 29th with an indurated sore ("a hard disc not ulcerated") of six weeks' duration. Mercury prescribed. October 19th, Sloughing ulceration of tonsils. |

The sore for which Mr. S—— came on the second occasion was not in the site of the first one, but on the opposite side. I saw both the sores myself, and on each occasion the induration was most characteristic, as well as the state of the glands. The case affords a good example of the success of the suppression plan of treatment. My belief is, that on each occasion the sore throat was specific, but on both it yielded quickly to the treatment. On each occasion the gland mass was at first unusually large, but on neither did suppuration occur. He was liable to sore throats in boyhood, and had had his tonsils excised.

## GOUT AND RHEUMATISM.

### No. XXVIII.—*An instance of Severe Gout with tophi in a woman—Note as to the state of the teeth in Gout.*

It is not very common in English practice to see gouty concretions in women. A lady of 67, who was florid and in excellent health, consulted me on account of an erythematous form of dermatitis approaching eczema. It occurred on her knees and face, and more or less on all parts of her body. She herself attributed it to a shock which she had received from the sudden death of her husband about two years ago. It had not been continuous since that time, but it showed itself very shortly after the shock, and had been recurrent ever since.

There were some interesting facts in this lady's history. She was of gouty family, and had herself suffered from repeated attacks of gout. On her hands and feet there were large chalky concretions, which were quite quiet and painless. She told me that her father was a brewer, and that in her girlhood he had always insisted upon her taking beer. She had drunk beer all her life until the age of 53, when, in consequence of her repeated attacks of gout, she had been advised to substitute whisky. In girlhood she had been very liable to herpes on her lips. About the age of 19 she remembered having a severe illness, which was called inflammation of the kidneys. With that exception she had enjoyed good health through life, and, at the age of 47, she had been successfully operated on for an ovarian tumour by Sir Spencer Wells. Her gout had of recent years been quite in abeyance, and it is to be observed respecting the eczematous condition

of the skin, to which she had become liable, that it did not begin until many years after she had given up taking malt liquor and had been free from gouty attacks. During what we may call her gout-period she had no eczema; and she began to suffer just at the age at which many other persons, not in the least gouty, become liable to dermatitis.

I have just another fact to add. Well preserved teeth are, I believe, not uncommon in families in which gout prevails, but it is not often that we see such a set as this lady presented. She had not lost a single tooth, and she said that she had only once in her life known what toothache was. She had four daughters, who had all been brought up to drink claret, and none of them showed any gouty symptoms.

## No. XXIX.—*Gout and Relapsing Eye Inflammations —Importance of change of climate as a measure of treatment.*

Miss Q——, a lady of forty-eight, came under my care on account of very chronic disease of her eyes, which had reduced her to almost total blindness. Her left eye was quite blind, and had been so for long; with the right she could see only $\frac{2}{1}\frac{1}{0}\frac{}{0}$. Her history was as follows. Her maternal grandfather and one of his sons, her uncle, had suffered very severely from gout. She had herself been a delicate child, and very liable to chilblains. She had never been kept in bed by rheumatism, but had often suffered much from rheumatic pains and had had sciatica. She had also been troubled with piles. She had been accustomed through most of her life to take beer or stout to lunch and dinner. The disease of her eyes had been threatened at the age of twelve; but on that occasion she wholly recovered, and remained quite well until she was twenty-two. At the latter age she became liable to attacks in the right eye, probably of the nature of cyclitis. For several years her left eye, as far as she could remember, remained free. Afterwards she became liable to recurring attacks, first in one and then in the other, and during the last few years she had rarely been

free for more than a month or two at a time. She had been under the care of a very able specialist, by whom repeated iridectomies had been performed in the hope of arresting the disease. Sir William Bowman had dissuaded her from any attempts at cure by operation. When I was consulted, the left eye was in such a condition that I advised its excision. The whole cornea was leaden, and bulging with dense white opacities here and there. In the right eye there were large opacities in the vitreous, iritic adhesions, and marginal opacities in the cornea. The disc could still be seen, and I could not detect any choroidal mischief. The tension of the eyes was slightly —.

I place this case on record as a good example of the final result of relapsing inflammation of the eyeball in connection with inherited gout. These inflammations may vary somewhat in their character in different cases, but their especial feature is a tendency to relapse and finally destroy the organ. The iris, the ciliary region, and the cornea are usually all involved together, and the early formation of opacities in the vitreous is a very common event. So far as my experience has gone there is but one method of treatment which ought to be trusted, and that is a complete and prolonged change of climate. The performance of iridectomy, although to a certain extent beneficial when there is tendency to closure of the pupil, is but a very uncertain remedy. It does not prevent relapses, and although, as in the present case, it may be repeated several times, the final result is usually disappointing. Nor is the use of tonics or of mercury or iodides more satisfactory. On the other hand, I have never known a case in which complete change of climate, and especially residence in a semi-tropical country, did not arrest the disease. Several of my patients have gone abroad for permanent residence, but in a few very definite examples a year's residence abroad has appeared to be sufficient, and no relapse has occurred on return to England. I have recently been made acquainted with the result in a case of this latter class, which at one time caused me much anxiety. The patient was a young married lady who had several relatives in the medical profession. She had a strong inheritance of gout,

and had become liable to recurring attacks of iritis. My recommendation that she should go to South Africa or some similar place for a full year was strongly opposed, on the ground that liability to such attacks as she suffered from made it necessary that she should remain within reach of good specialist advice. I insisted that change of climate would be her only remedy, and succeeded in prevailing upon her husband to take her abroad. She returned from an eighteen months' travel in South Africa, Australia, and New Zealand in strong health, and with her eyes perfectly well. It is now six years since she came home, and I was told not long ago by one of her relatives that she has remained without relapse. Had she not tried the radical measure of change of climate, I have little doubt that her case would have run the same course as the one which I related before illustrates.

## No. XXX.—*Severe Osteo-Arthritis in a Boy—Remarkable distortion of joints, &c.* (*with portrait*).

The illustration which I have here given is a copy of one published by Mr. Thomas Brayne, of Banbury, in the Transactions of the British Medical Association in 1834 (p. 366). The subject of the case was a boy aged seven, born of healthy parents, and the sixth of eight children. The other children were fairly healthy, but more or less strumous. In the case of the patient some symptoms of stiffness about the right elbow were observed during the first month or two of infancy. After that the child suffered continuously from diarrhœa, with emaciation of his body and limbs and enlargement of most of his joints. The diarrhœa continued, in spite of much treatment, during two years, and then gradually abated. There was very troublesome prolapse of the rectum, and the fæces were intolerably fœtid. No tumidity of the abdomen was observed until he was three years old.

At the time the sketch was taken the child, aged seven, is described as having a sallow aspect and rather vacant expression, though he had good mental powers. His skin was dry, and on his forehead, neck, and shoulders were "spots like

the psoriasis guttata of Willan." His voice was squeaking, as though uttered through a reed; but there was no enlargement about the throat, either of the larynx or the thyroid glands. The shoulders were high and the sternum prominent. He could not materially alter the position in which he is represented, and his back was stiff and curved, and his kness and elbows "ankylosed." The anterior fontanelle was not quite closed. The cranium measured in circumference round the temples twenty inches. None of the long bones were in the least curved. As regards the enlargement of the joints, it would appear to have been supposed by the describer to be chiefly due to the overgrowth of epiphyses. On this point I must give the exact words of the writer: "The bones of the pelvis, and upper extremities of the thigh bones, present nothing unusual; the latter have the natural degree of curve in their bodies, but, in the view taken, the thighs are entirely concealed by the enlarged knees. The right knee measures one foot seven inches in its greatest circumference, and is as large as the head within one inch. The relative proportion of the articular end of each bone which enters into the composition of the joint, as well as the situation of the patella, can be discovered by careful examination, and they all seem enlarged in nearly the same degree. The surface feels hard and unyielding, and large veins ramify over it, adding to the dark red colour which the skin has acquired from long distension. The integuments of the intestines between the bones are very slightly œdematous. The left knee measures only one foot three inches in circumference. The elbow, wrist, and ankle joints are also greatly enlarged, as the figure represents. The elbows are also so much ankylosed that all flexion and extension are destroyed, so much so that he can only reach his lips with the ends of the fingers of the left hand, and this with the greatest difficulty. The hands are only the size of those of a child of two years old, and the fingers are clumsy and ill-formed."

This remarkable case may, I think, be suitably allowed to stand as a type form of a certain group, in which severe epiphysial disease occurs in young children. It may possibly be in some degree allied to rickets; but at the same

time it is quite possible that it is nearer to chronic rheumatism or osteo-arthritis. We need to have our terms carefully defined before we engage in any controversy as to the appropriateness of one or other of these names. What is proved is that a child became the subject, in early infancy, of a widely spread affection of the epiphyses of the long bones, which resulted in great permanent enlargement of them, and so much stiffening of joints that it was called ankylosis. There was no bending of any of the long bones, and, although in connection with this it is to be remembered that the child had probably never made much effort at walking, yet we have the corroborative fact (against the idea of rickets) that the chest showed no special degree of malformation. The child was the sixth of a family of eight, and was suckled by a mother who had successfully nursed the others. It seems tolerably clear that the disease was an affection of epiphyses, inflammatory in character, and leading to overgrowth, rather than a generalised defect of the bone formation process, which is our central conception of what is meant by rickets. Just as chronic rheumatism or osteo-arthritis does in the adult, we find that it exempted certain joints, whilst others suffered very severely. Thus the hips and the shoulders escaped, whilst the elbows, wrists, knees, and ankles were all involved. It may have been that the small joints of the hands suffered, for it is stated that the fingers were clumsy and ill-formed. Taking all the facts together, it appears to me more likely that the disease was, as regards its cause—which, I submit, is the only safe basis for diagnosis—much more nearly allied to chronic rheumatism than to rickets. It may have been that the two were mixed together, for probably but few infants, suffering through long periods from any cause of exhaustion, such as, in this instance, profuse diarrhœa, wholly escape some tendency to the rickety state of nutrition. The occasional association of diarrhœa with rheumatic tendencies is well known, as has been the subject of record especially in connection with prisons. Any exhausting disease, indeed, such as diarrhœa or repeated and profuse losses of blood, menorrhagia, and the like, may become the foundation, in those hereditarily predisposed, of chronic rheumatic arthritis.

*West, Newman, lith*

Anything of the nature of the latter malady is, of course, rare in infancy; but it is by no means unknown, and we may readily recognise the probability that in young and rapildly growing bones it might produce extraordinary malformations.

## No. XXXI.—*Suppuration in Gouty Arthritis.*

It is fifteen years since I attended Mrs. C—— for acute gout of the right ankle, which suppurated. I had to open the joint, and under treatment by spirit lotions it healed without anchylosis. It was put up in plaster of Paris. It was a year or more before she could walk on it. She went about on crutches for long.

During the last twelve years she has walked on the foot with impunity. The foot is twisted somewhat outwards, but there is tolerable motion at the ankle joint. She is able to digest stout, and it appears to suit her. She has continued ever since to take some form of stimulant, either stout or wine. She has often been threatened with gout in her toes, but has never had a definite attack. Her fingers are become affected by nodi digitorum, and she has been under Sir Alfred Garrod's care for effusion into the left knee. There are decided lips. Mrs. C—— is tall and thin (58).

## No. XXXII.—*Effect of the Indian climate on Gout.*

Residence in India is beneficial to gout. Colonel S——, himself gouty, and inheriting in the strongest degree, tells me that his brother who serves in India is always well there, but gets an attack as soon as he comes to England.

# A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

## No. CLXVI.—*The Thyroid Gland.*

QUESTIONS.

1. Describe the operation of removal of the thyroid gland.
2. What precautions are of most importance?
3. Why would you not remove the entire gland?
4. What happens to the portion of gland left?
5. What is meant by the term "cachexia strumipriva"?
6. What is myxœdema?
7. What is the supposed function of the thyroid?

ANSWERS.

1. The gland is to be laid bare by a free crucial incision, the vessels are to be tied as they enter the gland, and the latter is to be carefully dissected out.

2. It is desirable not to cut or tear the gland-capsule; no vessel is to be cut before it is ligatured, and some portion of the gland is to be left.

3. Because removal of the whole leads to a serious condition of ill-health.

4. The portion left behind usually takes on hypertrophic growth (Horsley), and discharges the functions of the whole.

5 & 6. Cachexia strumipriva is the state of ill-health which follows removal of the thyroid, and is much the same as myxœdema. In both the face swells and becomes featureless, and the skin and cellular tissue generally become thick and flabby. The mental powers fail, and the patient becomes weak and half idiotic.

7. It is believed that the gland has an important influence on the formation of red blood corpuscles.

## No. CLXVII.—*The Treatment of Myxœdema.*

QUESTIONS.

1. To whom do we owe the suggestion as to the treatment of myxœdema by administering the thyroid gland of animals?
2. What were the details of this method first employed?
3. Is it necessary to resort to hypodermic injection?
4. Is there any danger in the use of too large doses?
5. Has the experience of observers been tolerably uniform as to the good results obtained?

ANSWERS.

1. As with most discoveries, there have been various steps. To Professor Kocher and Mr. Victor Horsley we are indebted for the demonstration of the connection between loss of the thyroid and myxœdema, and for the suggestion that the healthy gland of animals should be ingrafted. Dr. Brown-Sequard is to be credited with general and important suggestions as to the possible value of the juices of special glands injected subcutaneously. G. Vessale first made injections of the extract of the thyroid gland in dogs. To Dr. G. R. Murray, of Newcastle-on-Tyne, belongs the credit of having been the first to adopt the practice for the cure of myxœdema.

2. An extract of the thyroid gland of a sheep was prepared by mincing the gland and mixing it with glycerine and a weak carbolic acid solution. In this way a turbid pink liquid was obtained, and twenty-five minims were injected beneath the skin twice a week. The total amount for the week corresponded to one lobe of a sheep's thyroid. The frequency of the dose was gradually reduced.

3. It has been found that the gland is quite as effectual if given by the mouth, either mixed with beef-tea, or minced or thinly sliced and eaten as a sandwich. Of course it must be taken uncooked.

4. If the dose be too large the patient may suffer from vomiting, headache, and general malaise; but nothing more serious has occurred (with possibly one exception).

5. All observers seem to be agreed that this method of treatment is capable of curing the disease. The only point yet to be decided is with regard to the occurrence of relapses, after the administration of the gland has been discontinued.

## No. CLXVIII.—*Herpetology.*

QUESTIONS.

1. Does herpes ever occur within the urethra, and if so, under what circumstances?

2. What symptoms would lead you to diagnose urethral herpes?

3. What are the peculiarities of herpes when it follows quickly on constitutional syphilis?

4. How would you treat herpes when it occurs in a patient who has recently had syphilis?

ANSWERS.

1. Herpetic affections of the urethra, although not common, certainly do occur. The part affected is usually within a short distance of the meatus, although it is quite possible that it may occasionally be much lower down. It usually follows either syphilis or gonorrhœa.

2. Sometimes, without the use of the endoscope, a group of little white sores may be demonstrated. In most cases the diagnosis must be based upon the history. Repeated recurrences, short duration, and spontaneous recovery, imply herpes.

3. When herpetic affections occur in those who have recently had constitutional syphilis, they are apt to deviate from the rule of spontaneous recovery. The sores caused often linger for a time, or may degenerate into unhealthy ulcers.

4. If a patient who has recently had syphilis should become the subject of recurring herpes, whether on the genitals or within the mouth, the treatment should be compound. Both mercury and arsenic should be given. Arsenic is the specific for the herpetic element, and mercury for the modification of type which it will assume in connection with syphilitic taint.

## No. CLXIX.—*Herpetology.*

QUESTIONS.

1. Is herpes of the pharynx common?

2. How would you diagnose a herpetic sore throat?

3. Is herpes of the throat always in association with constitutional syphilis?

4. When in association with syphilis, can it be prevented by the administration of mercury?

5. What is the best remedy for the prevention of throat herpes?

ANSWERS.

1. Herpetic affections of the pharynx are not at all infrequent, and their recognition is very important.

2. As a rule, herpetic affections of the soft palate and pharynx are, like shingles on the body, strictly unilateral. Exceptions to this are, however, far more common than in the case of common shingles. This one-sidedness is a valuable means of diagnosis. It is aided by the grouping of the sores, by the great amount of tenderness which usually accompanies them, by the history of a sudden onset and tendency to spontaneous decline.

3. Most of the patients who suffer from recurring herpes in the mouth, whether tongue, cheeks, or throat, have previously been the subjects of syphilis. Some very characteristic and severe cases occur, however, without any such association.

4. The nature of the connection between syphilis and herpes is not well understood. As a rule, mercury does no good in preventing the latter.

5. Arsenic will usually prevent recurring herpes in the throat, whether it follow syphilis or not. It should be given for a long time, six months or a year, in doses of not less than three minims of Pearson's solution.

## No. CLXX.—*On Suppression Methods of Treatment.*

QUESTIONS.

1. What is the meaning of the term "suppression" as applied to the treatment of disease?

2. Under what three names may our usual methods of treatment be roughly grouped?

3. In what diseases is the "suppression-treatment" to be recommended?

4. Is it possible to suppress syphilis?

ANSWERS.

1. The term "suppression treatment" is proposed as an improvement on that of the "abortive treatment," since the latter term is liable to be misunderstood. By suppression we mean an attempt to interfere with and prevent the natural evolution of any malady of which the stages are known.

2. We speak of preventive treatment, when we endeavour to anticipate and prevent the access of any special cause of disease. We may even extend the use of the same word to cases in which the cause having been applied we endeavour to take it away again, and thus to modify its effects. The term "suppression-treatment" may be suitably restricted to cases in which, it being impossible to take away the cause, we yet seek to counteract and prevent its effects. A third group of measures may be called expectant or opportunist. These terms are applicable when we are content to place the patient under favourable conditions for recovery and to allow the disease to run its natural course, interfering only when special complications arise.

3. We habitually practise what we may call suppression treatment under a great variety of conditions, and more especially in reference to local maladies. The idea that the malady should be allowed to run its course, "that it is better out than in," is one which, as our means of cure are multiplied, is steadily losing ground. Syphilis is, however, the malady, in reference to the treatment of which the term "suppression" receives its most definite application.

4. It is easily practicable, by the early and systematic use of mercury, to prevent the evolution of syphilis.

## No. CLXXI.—*Ophthalmoplegia.*

QUESTIONS.

1. What is meant by the term "ophthalmoplegia"?

2. How is ophthalmoplegia interna distinguished from ophthalmoplegia externa?

3. Of what malady is ophthalmoplegia interna frequently a premonitory symptom?

4. Under what conditions is symmetrical ophthalmoplegia externa met with?

ANSWERS.

1. The term "ophthalmoplegia" is applicable to any form of paralysis of the muscular apparatus of the eye. It is convenient, however, to restrict its use to cases in which more than one nerve is implicated. As regards the latter, it is sufficient to name the nerve involved.

2. The term "ophthalmoplegia interna" is used in reference to the ciliary muscle and the iris, whilst that of "ophthalmoplegia externa" is applied to the muscles which move the eyeball.

3. Ophthalmoplegia interna, resulting in loss of accommodation and a motionless pupil, is not infrequently a premonitory symptom of tabes. When it stands quite alone it may be plausibly attributed to disease of the lenticular ganglion.

4. Cases of symmetrical ophthalmoplegia externa, in which both eyeballs become more or less fixed in the orbits and the upper eyelids droop, are seldom met with except in the tertiary stage of syphilis. They have, however, been known to occur after injuries to the head.

## No. CLXXII.—*Dr. Meade on Erysipelas.*

Dr. Meade, a century and a half ago, wrote of erysipelas as follows:—

"Great attention is to be given to that fever which is accompanied with an erysipelas. For in this, besides the pain, thirst and restlessness, which the patient suffers, the pustules on various parts of the body sometimes run into gangrenes. Wherefore the first thing to be done is, to draw blood pretty plentifully, and then purge once and again with gentle cathartics, as infusion of senna with manna. For such only are proper in fevers. And indeed there is no acute fever that

bears repeated purging better than this, especially when the inflammatory tumour has seized the head; for the humour spreads very fast, and soon gains the neighbouring parts."

QUESTION.

In what respects have our opinions respecting erysipelas been modified since Dr. Meade wrote?

ANSWER.

Most will probably admit that it is more correct to speak of the fever which attends erysipelas than of the erysipelas which accompanies fever. Many, however, still adhere to the doctrine so distinctly avowed by Mead, that erysipelas is a fever, *i.e.*, that general blood changes precede local phenomena. All, however, have ceased to rely upon depletion as a measure of treatment. We now rely far more upon local treatment, and in doing so make a partial acknowledgment that we do not trust the doctrine of constitutional origin. Even in prescribing tincture of iron, as is now so properly and almost universally done, we look to the action of the remedy upon the blood vessels of the part rather than to any influence on the general health.

## No. CLXXIII.—*Malformations of the Teeth.*

QUESTIONS.

1. How would you distinguish between the malformations of teeth due to syphilis and those consequent on stomatitis?

2. What are the peculiarities of the central permanent incisors, which are trustworthy as diagnostic of inherited taint?

3. May any other conditions be trusted for diagnostic purposes?

4. Are the malformations due to stomatitis in infancy often met with coincidently with those of syphilis?

5. Apart from the malformations of stomatitis and those of syphilis, what other peculiarities of the teeth may be recognised?

ANSWERS.

1. The teeth to be looked at, in reference to the diagnosis of inherited syphilis, are the upper central incisors of the permanent set. Unless these teeth are malformed, all other defects are to be disregarded. The test teeth for stomatitis are the first permanent molars, and unless these teeth are defective in their enamel, any defects which the others may exhibit are to be disregarded.

2. These teeth ought to be smaller than natural, less wide at their edges than at their crowns, and with a single broad notch in the middle of their edge. These several peculiarities may be more or less well marked in different cases, but ought all to be present if the diagnosis is to be beyond doubt.

3. Many teeth are sufficiently malformed to cause suspicion, which yet do not justify a confident diagnosis. Many are also quite characteristic to a well skilled observer, which yet do not present peculiarities that it would be safe to describe as trustworthy.

4. Syphilitic teeth are very frequently seen in company with those which are malformed as the result of stomatitis in infancy. This results from the obvious fact that many, if not most, syphilitic children have been treated by mercury in infancy. This very frequent coincidence of the two kinds of malformation has led to much misconception as to what the true characters of syphilitic teeth are.

5. There can be little doubt that by far the larger number of cases in which the enamel formation is imperfect are due to stomatitis of some kind in infancy. Peculiarities in the form of the teeth, "rat teeth" for instance, may be met with without any assignable cause ; and the conditions known as " craggy teeth " are occasionally a family peculiarity, and do not imply any preceding stomatitis.

## No. CLXXIV.—*Errors in the Diagnosis of Small-pox.*

Amongst the cases which are sent into our Hospitals for Infectious Diseases there are always some in which the diagnosis, when it comes to be submitted to skilled specialists,

is open to question. Thus I find that Dr. McCombie, of the South-Eastern Fever Hospital, states that 25 out of 89 patients sent to him during one year as suffering from small-pox were found not to have that disease.

QUESTIONS.

1. What eruptions are liable to be mistaken for small-pox?
2. Are syphilitic eruptions often mistaken for small-pox?
3. How should varicella be diagnosed from small-pox?
4. What measures would be adopted in the event of a patient having been admitted into a small-pox ward and then found not to have the disease?
5. Does chicken-pox ever cause death?

ANSWERS.

1. In nine out of ten cases the disease mistaken for variola is varicella. The remaining tenth is probably made up of syphilitic and lichenoid eruptions.
2. Yes, not unfrequently.
3. The rapid evolution without premonitory symptoms in varicella, and the contrast between the shotty papule of small-pox and non-indurated vesicle of varicella, will generally suffice. In severe varicella, however, the papules may assume a certain degree of hardness and there may be definite fever. In puzzling cases seek for freshly formed spots and note whether induration precedes the vesicle. In small-pox, induration comes first; whilst in chicken-pox, if it comes at all, it follows the formation of a little pellucid vesicle.
4. The patient should be at once vaccinated and transferred to an isolation ward, where he should remain a fortnight.
5. The registrars' reports contain every year a certain number of deaths recorded as due to chicken-pox. They are probably, however, deaths after chicken-pox, and in consequence of its sequelæ, rather than during the fever itself. The sequelæ of chicken-pox are sometimes severe, multiple abscesses, &c.

## No. CLXXV.—*Malformations of the Teeth.*

QUESTIONS.

1. To what class of causes are defects in the milk teeth usually due?

2. In the subjects of inherited syphilis do the milk teeth usually wear well?

3. To what is the destruction of the milk set of incisors probably due?

4. Do the milk teeth ever present any peculiarities of form which are characteristic of syphilis?

5. How do you explain the fact that the milk teeth in inherited syphilis show no defects in their enamel as the results of mercurial treatment in infancy?

6. What peculiar condition of the eye is often met with in association with mercurial or stomatitis teeth?

7. How do you explain this association?

8. If a patient has had convulsions in infancy, and has yet taken no mercury, will any defect in his teeth be present?

9. Is it easy to make errors in diagnosis as regards the recognition of syphilitic teeth?

10. Are the conditions ever such as to warrant complete confidence?

ANSWERS.

1. It is very probable that the use of mercury by a pregnant woman, in a late period of gestation, may cause damage to the enamel of the first set of teeth. Stomatitis, whether mercurial or otherwise, if occurring in the first few months of life, may very possibly damage the first set of teeth so as to cause early caries.

2. No; it is very common for them to "rot away," as it is said, by caries which begins at the crown. Syphilitic children are often, as regards their incisor teeth, wholly without them for several years before the permanent set comes up.

3. It is very possible that this is due to the use of mercury during the first few months of life.

4. No; they are almost invariably well formed, but are liable to early caries.

5. The crown of the tooth is usually well calcified before

the mercury is given, whilst the neck and fang have yet to be formed.

6. The subjects of what is known as lamellar cataract almost invariably present those defects in the formation of enamel which constitute what are known as the mercurial teeth.

7. Lamellar cataract is usually met with in those who have suffered severely from convulsions in infancy, and it is to the use of mercury for the relief of the convulsions that the defects in the teeth are due.

8. There is good reason to believe that the convulsions have no direct influence on the teeth, and that the spoiling of the latter is due only to the remedy used.

9. Yes; the conditions are often so ill-marked that great care is necessary in their appreciation.

10. When well characterized they may be trusted implicitly.

## No. CLXXVI.—*Questions without Answers.*

Is the presence of a brain necessary to perfection in the development of the limbs of a fœtus?

Is it possible for a fœtus to live and grow without any central organ of circulation?

What is the incubation period of small-pox?

At what period after contagion may a chancre be expected to show induration?

Is measles more dangerous to a child or to an adult?

Is it possible to successfully inoculate calves with human small-pox?

What is the difference between vaccination and variolation?

What is the conventional distinction between mortality and fatality?

Which nerve of the brachial plexus is the most liable to injury in dislocation of the humerus?

Where does the head of the humerus usually rest in dislocation downwards?

Can varicella be transmitted by inoculation?

What disease is often miscalled sciatica?

Of what do gout tophi consist?

# PLATE LXIX.

## KAPOSI'S DISEASE.

This lithograph has been copied from a portrait kindly lent to me by Dr. Radcliffe Crocker. It is taken from a patient whom I have myself seen. I reproduce it on the present occasion, in order to illustrate the proposition that the malady known as Kaposi's disease ought to rank as a family form of lupus. It has perhaps a nearer relation in certain particulars to lupus erythematosus than to lupus vulgaris, but it probably partakes of the characters of both. It might possibly be suitably known as lentigo lupus, or the lupus that attacks freckles. It is a family disease, almost always attacking three or four members of the same family, and commencing in early life. It is clearly evoked under the influence of exposure to sunlight, and its first stage is one of extensive freckling, affecting the face and hands. Next follows a stage of ulceration, and bossy masses of granulation grow out; and finally there is a tendency to develop fungating masses, which are of the character of epithelial cancer. In most of these features it has close parallels to certain cases of lupus. In the portrait given it will be seen that the girl's neck is covered with freckles. The tip and alæ of the nose have been destroyed, almost in the same manner so often seen in lupus; whilst on various parts of the face, more especially just in front of the right ear, there are ulcers, covered by bossy masses of soft granulation structure. That on the ear was, I believe, already carcinomatous. Three or four brothers and sisters suffered from the disease. The cases have been fully published by Dr. Radcliffe Crocker in the 'Medico-Chirurgical Transactions.'

# PLATE LXX.

## LUPUS VULGARIS AFFECTING THE NOSE AND LIPS.

This Plate is the portrait of a young lady who died of pulmonary phthisis about a year after it was taken. She was of a somewhat delicate family, and one of her sisters suffered from lupus of the septum nasi. There was no syphilis in the case. The portrait was taken in order to show the very extensive ravages which occasionally attend lupus when it attacks the lips. It will be seen that the whole of the parts around the mouth have been destroyed, together with the entire upper lip and a great part of the nose. The ulcer was usually crusted over with a thick scab, and readily bled when the latter was removed. The treatment had, in the earlier part of the case, unfortunately been neglected, on account of the patient's unwillingness to submit to the pain which it caused. Had she survived, it is probable that the final condition, after cicatrisation, would have resembled that shown in the woodcut given at page 376, Vol. IV.

*West, Newman, lith.*

# PLATE LXXI.

## LUPUS MUTILANS.

In this lithograph we have shown the hand of a young woman, in whom lupus had commenced in early childhood. The skin of the entire hand and of the lower part of the forearm had been reduced to a condition of scar. The two ulnar digits had been entirely destroyed, and the other three shortened and deformed. The mutilation much resembles that which is sometimes seen in cases of leprosy. It had been brought about partly by inflammation of the bones of the digits and partly by their interstitial absorption.

I have seen but very few cases of lupus mutilans resembling the condition here shown. In all it was associated with lupus vulgaris on other parts, and in all the disease had begun in early life. It is, I suspect, necessary to the production of the exaggerated conditions here shown, that the disease shall begin in youth, and that it shall spread over the whole hand. The late Mr. Sibley once brought to me a patient, suffering from lupus of the face, one of whose hands was exactly in the condition shown in this Plate. She was a lady of about thirty years of age, and had suffered from childhood. A similar condition is sometimes produced in the foot.

*West, Newman, lith*

# PLATE LXXIX.

## LUPUS VULGARIS.

In this Plate I have endeavoured to represent the conditions not unfrequently shown, when lupus vulgaris attacks one of the extremities. Owing no doubt to peculiarities of the circulation in these parts, and their great liability to suffer from exposure to cold, lupus processes, when affecting them, are always attended by an excess of inflammatory action. On the hands and feet we never see the quiet, uninflamed, apple-jelly patches which are so characteristic on other parts of the body. On the other hand, œdema, congestion, ulceration, granulation masses and thick crusts are the ordinary conditions. In the present instance the crusts have been cleared away, and ragged ulceration, with much thickening of the adjacent tissues and bossy granulation lumps are seen. It will be observed that the middle toe is swollen and livid. The lupus had commenced, as it often does in young persons, between the toes, and had been gradually spreading for several years. The patient was a girl of fifteen, who had lupus presenting its more ordinary conditions on other parts.

This is the condition which, when more extensive and occurring at an earlier period of life, may end in such mutilation as that shown in Plate LXXI.

West, Newman, chromo.

# PLATE LXXX.

## ECZEMA-LUPUS.

In this Plate it has been endeavoured to delineate one of the forms of lupus which is often diagnosed as eczema. The patient was a young woman in whom lupus vulgaris affected both ears. On the right side it occupied the concha, and on the left it was behind the ear. Thus the conditions were not symmetrical. The disease had been present for some years. It will be seen that beneath the patch behind the left ear there is a scar. The fact that a scar is left, when the lupus process undergoes resolution, is conclusive in the diagnosis from eczema. The form of lupus to which the term eczema-lupus may be conveniently applied, is often much more peculiar and more closely resembling eczema than that delineated in this Plate. It is very superficial, and wholly unattended either by apple-jelly deposit or the granulation masses, which are so common in lupus vulgaris. Its surface weeps freely, or may form a thin eczematous crust. Its resemblance to eczema is indeed so close that it is almost constantly diagnosed under that name. Its persistence, however, in spite of treatment; its extreme chronicity, and the fact that it always leaves scars as it recedes, are conclusive as to its being of the nature of lupus. It is a rare condition.

*West, Newman, chromo.*

# PLATE LXXXI.

## A MIXED FORM OF LUPUS-NÆVUS.

Two conditions are represented in this sketch, which must not be confused with each other. The round spot on the back of the forefinger was nothing but a common wart, and was easily and permanently cured. The patches, seen near the base of the thumb, were of a totally different nature. They had been present for many years, and were gradually spreading at their edges in the manner of lupus. They were in fact just about to coalesce. They consisted in part of nævoid tissue, in part of low papillary growths; They differed from the ordinary nævoid condition in that it was not possible to empty some of the vessels by any amount of pressure. It is obvious that they also differed from ordinary nævus in their tendency to spread by infection of tissue, and to produce satellites. I possess several portraits which illustrate different stages of this case. The patient was a girl, aged about twelve. After she had been for a year or more under my observation, she was operated upon at one of our hospitals by the actual cautery. A very large and deep sore was produced, which was long in healing. After healing was complete the scar took on a nævoid condition, which at present, six years later, it still displays. There is, however, no longer any tendency to papillary growth.

*West, Newman, chromo.*

# PLATE LXXXII.

## LUPUS VULGARIS OF THE NOSE.

The tip of the nose partakes of the peculiarity, as regards its nutrition, circulation, and liabilities to disease, of the hands and feet. Like them it is liable to chilblains and to frostbite. When affected by lupus, the process is almost always attended by excess of inflammation. The part swells, ulcerates, and becomes covered with scab. The quiet stage of apple-jelly infiltration is rarely observed. These statements are well illustrated in the Plate here given. It was from a girl aged about seventeen. The proneness to ulceration, when the nose is attacked by lupus, led in former days to the use of such expressions as "lupus exulcerans," "lupus exedens," and the like. It is now well recognised that these adjectives were applied rather to peculiarities assumed by the lupus process on a special part of the body, than to any specialised form of the disease. Lupus at the end of the nose is, in nine cases out of ten, attended by ulceration and destruction of the part (exedens).

*West, Newman, chromo*